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ABSTRACT

The major purpose of the report is to reveal through case-study examination how seven carefully selected medical faculty practice plans evolved and how they work. The satisfactions and dissatisfactions of faculty and administrators were determined in on-site interviews. Among the findings and conclusions: (1) medical practice plans have become an essential element in the structure of medical schools; (2) although the primary use for income from these plans is the support of clinical faculty salaries, the income increasingly supports school-wide programs; (3) the importance of an organized and written plan is evident for harmony within the institution; (4) good management is as important as good initial planning; (5) preoccupation with fiscal matters is troublesome to faculty members; (6) in a number of instances faculty practitioners are provided malpractice insurance, space, and staff without paying full cost; (7) inadequate or widely dispersed physical facilities for ambulatory care are felt to be major problems at some schools; (8) greater flexibility in the use of practice funds has become essential in meeting the program commitments of all schools; and (9) although relationships between full-time clinical faculty and non-faculty community physicians can become strained, the practice plan can become a useful mechanism for achieving a favorable referral policy. (MSE)

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AN ANALYSIS OF THEIR EVOLUTION AND OPERATIONS

FINAL REPORT

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AN ANALYSIS OF THEIR EVOLUTION AND OPERATIONS

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

FINAL REPORT

December 1977

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EXECUTIVE SUMMARY

This report of the second year of the AAMC's two-year Study of Medical Practice Plans is an in-depth descriptive analysis of the evaluation and operation of seven diverse faculty practice plans. The first year of the study resulted in a national overview of the structural and management characteristics of 67 institutional plans, it presented a review of trends as to the way plans have functioned over the past two decades, and it advanced a scheme for classifying plans.[1]

Purpose

The major purpose of this report is to reveal through case study examination how seven carefully selected plans evolved and how they work. The satisfactions and dissatisfactions of medical school faculty and administrators have been determined by on-site interview and documented in the case studies. It is thus anticipated that those institutions about to design a plan for the first time, or those considering modifications in a present plan, can learn from the experiences of others.

Methodology

The method used to gather information for this report was on-site interview with a wide variety of medical school/center administrative staff and clinical faculty. This followed a process of site selection so that, using the typology developed by the AAMC in the first year of this study, representative types of plans were included, and medical school diversity was achieved. Case studies were then drafted, thoroughly reviewed and approved by the appropriate school official. Other AAMC data was included in the written studies to enhance insight into the way the plan evolved and functions.

Findings and Conclusions

1. Medical practice plans have become an essential element in the structure of medical schools. This is a consequence of the schools' desire to compete in the marketplace for quality, satisfied

faculty; to achieve program control and balance; and to counteract the reduction of other significant income sources.

2. Although the primary use for income from practice plans has continued to be the support of clinical faculty salaries, an increasingly significant purpose is broadened financial coverage for programs throughout the medical school.

3. The importance of an organized written medical practice plan universally applied to all practicing full-time clinical faculty in a medical school is becoming increasingly recognized nationwide as one way to contribute to a harmonious school environment. To have an unwritten plan irregularly applied is felt to invite morale and miscommunication problems.

4. Careful attention to the way a plan is written, reviewed and updated is crucial to a smoothly functioning plan. However, even though a well-drawn plan exists, if the plan is poorly managed and if there is inadequate communication between administrators and faculty as the plan operates, explosive situations can occur.

5. Many of the interviewed faculty felt there was a preoccupation with fiscal issues, e.g. billing and collecting procedures, at their institution. This was viewed as detracting from more worthy objectives such as using the plan and its practice environment as a model for health care delivery.

6. In a number of instances faculty practitioners are provided services such as malpractice insurance, space,and staff without paying their full cost either directly from their collections or indirectly through an overhead assessment. Frequently these practice costs are absorbed by the medical school or the teaching hospital.

7. Inadequate or widely dispersed physical facilities for ambulatory care are felt to be major problems at some schools, and as a result contribute to lax administration and weakened control over the faculty in their patient care activities. Well-planned practice areas that are

geared to an efficient operation can attract patients, make practice more attractive to the faculty member and make him more productive during the time he allocates to practice.

8. Greater flexibility in the use of practice funds has become essential in meeting the program commitments of all schools. This is especially true with public schools where state regulations governing hiring, purchasing and spending have become too restrictive and inflexible.

9. Although relationships between full-time clinical faculty and non-faculty community physicians can and do become strained for varying reasons, a practice plan can provide a useful mechanism for achieving a referral policy more favorable to the school. A well-developed plan can attract faculty with excellent clinical reputations, an inducement to more referral patients.

INTRODUCTION

The Association of American Medical Colleges has completed its two-year study of medical practice plans at U.S. medical schools. This review has reinforced the contention that no subject concerning medical school management has led to more agony and heated debate among the schools' administrators and faculty than that concerning the form and operation of service plans. The issue - thorny to say the least at many schools - has contributed to departure of deans and presidents, has brought about serious impasses between clinical faculty and medical school managers, and it has triggered great concern over which institutional mission should predominate - education or service. Because of the controversy surrounding practice plans, with much of the focus on "pocketbook" issues, the topic has continued on the agenda of innumerable meetings and workshops and has fostered a considerable number of consultations.

It is evident as one surveys the national scene that forces often outside the medical school, sometimes bureaucratic in nature, but more frequently economic, have led to the development and refinement of more and more medical practice plans. A practice plan is defined as a set of formal policies and procedures - usually written as a single document - governing the manner in which faculty physicians provide patient services, secure reimbursement and utilize the resulting income.

In 1976 with support from the Bureau of Health Manpower, the AAMC began its comprehensive study of medical practice plans extant at nearly seventy U.S. medical schools. The first year of the study resulted in an analysis of the characteristics of all plans available to the Association, a review of trends, the development of a scheme for classifying practice plans, and an annotated bibliography on the subject. The results of this effort have been published by the AAMC as Medical Practice Plans at U.S. Medical Schools, A Review of Current Characteristics and Trends (Volumes I and II), March 1977. The second year of the study has been essentially an in-depth examination of seven diverse plans. In contrast to the "anatomical" or structural focus of year one, the second year concentrated on developing a better appreciation in a "physiological" sense of how the plan evolved and how it functions. It will be helpful, if not necessary, for the reader of this report to have read the previous one.

Scope and Objectives

There are presently 112 established M.D. degree-granting fully accredited medical schools in the United States. During the first year of this two-year study, medical practice plans at 67 institutions were reviewed. Although the AAMC welcomed full participation by all of the schools, a number of plans were unavailable as they were either in the midst of major revision, still in a developmental stage, or in the case of at least a dozen schools, did not have any acknowledged plan.

The general objective of the first phase of the two-year study was to identify and describe the primary features of plans found to be operational nationwide. In the first-year's report cited previously, structure and governance, mechanics of administration, compensation patterns, and income flow and dispersal are described. Additionally, the objectives in year one included: (1) a review of national trends concerning practice plans; (2) the development of a rationale for classifying plans and grouping them accordingly.

The major purpose of the second year of the project was to reveal through case study how a sample of plans evolved and how they work. Satisfactions and dissatisfactions have been uncovered through on-site interviews with a wide variety of medical school faculty and administrators. It is anticipated that schools about to establish a practice plan for the first time, or those considering revisions, can profit from this report which describes the experiences of other schools.

The report for Phase I discussed the general historical development which has contributed in this country to the generation of practice plans. Recent contributory events were also presented, as was a Summary of other work in the field. The reports of both years of the study, it is hoped, will add to the rather sparse literature in the field.

METHODOLOGY

This section will describe the methodology for the in-depth, on-site examination of practice plans and the views of school participants at a selected group of medical schools.

Site Selection

The research design for this phase of the study indicated that the sample of schools would represent a proper balance of public and private institutions and a fair distribution of practice plan types. The tentative site selection was influenced by plan type and by institutional factors. The typology developed in year one of the study was used as a guide. According to the typology under which 67 plans were classified in the first year study, nearly half were Type A ("centralized"), over one-third were Type B ("intermediate") and the balance, Type C ("decentralized"). Structural characteristics of medical practice plans, as presented in the typology, were re-examined along with other plan features, e.g. recent revisions in plan structure and/or operation, income distribution schemes, and techniques used in plan implementation, in order to further discriminate among the variety of plans which might be included as case studies. Further, varying mechanisms such as financial audits, special billing systems and employment agreements used to implement the practice plan guidelines, were broadly represented among the case study institutions initially proposed.

With respect to institutional factors used in the selection process, ownership was a prime consideration. Two-thirds of the 67 schools included in year one of the study are public; the balance private. Other institutional characteristics were considered such as age, location, relationship with parent university, student enrollment, size of clinical faculty, and nature of clinical facilities.

A tentative list of study sites was selected. An alternate list was also compiled in the event an invitation to participate in the study was rejected by a particular set of schools. Letters were sent to the medical school dean or other appropriate official inviting par-

ticipation (see Appendix A). All schools initially invited agreed to participate.

The diversity resulting from the selection process is seen in Table 1. One additional explanation is in order, however, as initially six plans were selected for study. As the site visits which are discussed below took place it became evident that most, if not all six of the plans, were having significant problems and facing the prospect of major revision. It was felt that at least one plan should be a stable one and represent an institution with a high degree of faculty and administrator satisfaction. Thus, the seventh study (Case Study #6) was added.

Logistics of Site Visits

Site visits of a day and a half to two days at the case study schools were felt to be maximally productive if the composition of the visit team and the interviewees at the site were well chosen. A three-member visit team was judged to be the right size, and in general comprised one AAMC staff member and two members from the Study Advisory Committee. A conscious effort was made to have an academician as one of the visitors in order to maximize peer communication at the school. The Association staff member served as the team's secretary and had the ultimate responsibility for drafting the resulting case study.

Interviews

The selection of the visited institution's faculty and staff to be interviewed was left to the judgment of the school's initial contact, usually the dean. However, he was urged to select a variety of individuals representing not only different functions relevant to the plan, e.g. plan manager, hospital administrator, practicing physician, but also varying faculty ranks, disciplines, and attitudes. The team felt it important that a range of opinions be represented -- dissident and vocal as well as complacent. Most of the interviews were scheduled for a single individual for an hour, usually starting with an informal breakfast meeting with the dean (see Appendix B - Suggested Interview Schedule). Breaks in the interview schedule allowed time for the team to collect their thoughts and to summarize on tape the re-

sults of the interview(s).

A single assigned room was used for all the interviews for time efficiency. This was usually a location convenient to the majority of the respondents.

The site visit team concentrated its questioning on three broad areas: (1) history and evolution of the practice plan; (2) the operating mechanisms, to the extent they were unclear in the written plan (circulated in advance to the team members); and (3) the respondent's perceptions of the plan's objectives and his/her assessment as to whether those goals were being attained. Although it was planned to keep the interviews relatively unstructured, an interview guide was developed (Appendix C) with sample questions posed under major categories. These questions were neither all-inclusive nor were they asked of all interviewees. By and large they were intended to be open-ended and followed up with team probes to stimulate elaboration as necessary. It was recognized early on, that one important element of the case study reports would be the contrasts in perspective likely to emerge through the interview process. From this standpoint and that of achieving a very frank, open exchange with nearly every respondent, the interviews at each of the seven sites were considered by staff and consultants to be most successful.

Written Case Study

Following each institutional visit, it was the task of the team secretary (AAMC staff) to prepare the initial draft of that case study. It was planned that it should include the following: (1) summary page; (2) section indicating those institutional characteristics relevant to the plan; (3) general plan description and history; (4) report of the visit and findings as expressed by the interviewees; (5) team observations; (6) conclusions. The draft was circulated for comment to other AAMC staff and the other team members. A revised version was then sent to the school for approval (Appendix D). To the extent the dean or designee suggested changes, these were made and final approval then sought. With the exception of one school which did recommend substantive changes, the other institutions either accepted the report without modification or recommended minor changes in tone. The studies have also had editorial input from the study's Advisory Committee as a whole. The Committee felt that it was not necessary to hold to absolute consistency of

format. Rather the extent and nature of the plan issues and the availability of information about the plan should determine their treatment in the written study.

Use of Other Data

In preparing for each institutional site visit and as the case studies were drafted, the study's staff drew upon other AAMC data relating to that school and its practice plan. Such data already in Association files included accreditation reports, statistics from the Institutional Profile System, the written plan itself, and relevant correspondence. These materials provided greater insight into the way the plan evolved and functions.

RESULTS AND DISCUSSION

An Overview of Seven Medical Practice Plans

Basic Medical School Characteristics

Although the principal objective in selecting a group of medical practice plans for in-depth analysis was diversity, one consequence was a varied sample of medical schools. From the accompanying Table 1, one sees that of the seven represented, there are two private and five public schools, three of which are either free-standing or quite autonomous from a parent university. The year the school was organized ranged from the early 1800's to the 1960's. Four are located in the Northeast/Mid-Atlantic area, and one each in the South, Midwest and West. All of the schools are situated in urban centers; however, population size varies considerably from slightly more than 600,000 to about 9,600,000 Three sites are populated by under 1,000,000.

Relevant statistics for the seven institutions showed the following ranges: approximate number of undergraduate medical students - 260 to 680; house staff - 180 to 540; full-time clinical faculty - 80 to 440. Volunteer faculty at the seven schools are reported to number between 340 and 1,460. For 1975-76 regular operating income to the schools, that is revenue which discounts that associated with such sponsored programs as research grants, ranged from $12.4 million to $20.6 million. Practice plan revenue was reported as ranging from about $.6 million at one school to $9.7 at another. The resulting relationship of plan income to regular operating revenue was as low as five percent and as high as sixty-one percent.

As to clinical facilities, at six of the schools the major teaching hospital and the medical schools are under common ownership. The seventh, the teaching hospital is separately incorporated but affiliated. The total beds available among the major teaching hospitals are about 3,700 and range from 179 to 973 per hospital. Total clinical affiliations for the seven institutions number about 60.

The multi-page table which follows is formatted as a profile of the seven case studies. Basic medical school and plan characteristics are included.

Table 1

Profile of Medical School Practice Plans Selected for Case Studies

	Study #1	Study #2	Study #3	Study #4	Study #5	Study #6	Study #7
I. BASIC MEDICAL SCHOOL CHARACTERISTICS							
Year Organized*	1900	1800	1880	1880	1960	1840	1960
Ownership Status	Private	Public	Private	Public	Public	Public	Public
Region	Northeast	Northeast	South	West	Midwest	Northeast	Northeast
Number Undergraduates Medical Students*	420	680	340	520	260	480	500
Number House Staff*	540	420	360	620	180	320	440
Number FT Clinical Faculty*	260	280	260	440	80	200	240
Number Volunteer Faculty*	900	360	420	1460	340	700	700
II. BASIC PLAN CHARACTERISTICS							
Typological Designation	B	C	A	A	A	B	B
A. Organization							
Legal Structure							
Plan unincorporated within medical school	X		X	X		X	X
Plan separately incorporated from medical school					X		
Departmental options to select legal framework but plans collectively under medical school		X					
Implementation date - initial plan	1967	1958	1969	1959	1973	1959	1972
Date of latest major revision	1975	1975	1975	1974	None	1977	None
Discussion of plan evolution (page reference)	p. 39	p. 54	p. 64	p. 74	p. 89	p. 99	p. 108
Administrative Structure and Membership							
1. Nature of plan steering body	not operational	advisory	advisory	advisory	managerial	managerial	advisory
2. All clinical departments represented on governing body			X	X	X	X	X

* Rounded to nearest twenty; 1975-76 data

Notes: N.A. = Not Applicable

Table 1 (continued)

Profile of Medical School Practice Plans Selected for Case Studies

	Study #1	Study #2	Study #3	Study #4	Study #5	Study #6	Study #7
3. Clinical departments are represented equally	N.A.			X	X	X	
4. Clinical departments are represented unequally either by appointment, election, or according to such other criteria as practice volume, size of clinical faculty	N.A.	X	X				X
5. Presence of central plan office & manager	X		X	X	X		X
6. Membership in plan a condition of employment for full-time practicing faculty	X		X	X	X	X	X
7. Discussion of plan administration & membership criteria (page reference)	pp. 39-40 42-43	pp. 54-55	pp. 64-66 68-69	pp. 72,75 76,82	pp. 89-90	pp. 99-103	pp. 109-110
B. Plan Objectives							
Indicated in plan with some specificity		X	X	X	X	unwritten, but generally understood	X
Level of communication to faculty	poor	poor	good	poor	poor	moderate	poor
Nature of procedures for evaluation	none	formal	none	none	none	none	none
Discussion of objectives and evaluations (page reference)	pp. 47-50	pp. 54 59-60	pp. 65 68-70	pp. 74,78-79	pp. 89 94	N.A.	pp. 108, 122-123
C. Practice Setting							
Plan participants restricted to practice in school-owned or affiliated facilities	X	X	X	X	X	X	
Status of primary teaching hospital	affiliated	owned	owned	owned	leased	owned	affiliated
Level of cooperation between plan members and volunteer faculty	poor	moderate	variable	good	good	moderate	moderate
Discussion of practice setting (page reference)	pp. 37, 43-45 47-48	pp. 52 ,55	pp. 62-69 - 70	pp. 71,84	p. 86	pp. 96-98 102-104	pp. 105-107,119-121

Notes: N.A. = Not Applicable

Table 1 (continued)

Profile of Medical School Practice Plans Selected for Case Studies

	Study #1	Study #2	Study #3	Study #4	Study #5	Study #6	Study #7
D. Fee Management							
Fee Schedule Administration							
Highest organizational level of schedule approval	individual	department	plan committee	plan committee	individual	department	plan committee
Level having right to waive or discount fee	individual	department	individual	individual	individual	individual	individual
Billing and Collecting							
Centralized in plan office			X	X	X		
Centralized at departmental level		X				X	
Individual handles							
Combination of two or more of the above	X						X
E. Income Distribution							
Compensation							
A signed annual employment agreement exists indicating salary components	X	X			X	X	X
Individual incentive limited to % of base salary							X
Individual incentive limited by amount allowed each plan member		X	X			X	
Individual incentive limited by a standard amount which total compensation cannot exceed	X						

Notes: N.I. = No Information

Table 1 (continued)

Profile of Medical School Practice Plans Selected for Case Studies

	Study #1	Study #2	Study #3	Study #4	Study #5	Study #6	Study #7
Individual incentive variable among departments and from year to year				X			
Individual incentive unlimited, but base on progressive tax schedule					X		
Total compensation directly influenced by individual's patient service activity	X	in some cases			X		in some cases
Discussion of compensation distribution (page reference)	pp. 39-40 46-47	pp. 55-57 59-61	pp. 67-68	pp. 76-79-83	pp.91-93	pp.100-104	pp.109-112
Costs of Practice/Plan Overhead							
Level at which lab and other ancillary are billed	practitioner or plan	practitioner or plan	plan	plan	plan	practitioner	practitioner
"Off-the-top" assessment of gross collections made to support plan overhead, e.g. expense of billing and collecting (percentage of gross)	arbitrary 25%	N.A.	arbitrary 10%	actual cost	arbitrary 33%	N.A.	actual cost
Institutional Allocations							
Medical School/Dean's Fund	X	X	X	X	X	X	X
Earning department (discretionary account)	X	X	X	X	X	X	X
Echelons above medical school			X				
F. Prominent Issues Identified by Interviewees (page reference)							
Billing and collecting procedures	p. 45	p. 55-56			p. 94	p. 104	pp. 117-119 120-122
Communications between plan administration and plan members	p. 42-43	pp. 59-61			p. 94		pp. 115,116-119 122-123
Practice facilities	pp. 43-45		pp. 69,70				pp 119-120
Incentive arrangement	pp. 46-47			pp. 82-83 84			
Departmental distribution formulae	pp. 46-48	p. 59-60					
Management of fringe benefits	p. 47	p. 61					
"Town-gown" relationships	p. 48		p. 70				

Notes: N.A. = Not Applicable

Table 1 (continued)

Profile of Medical School Practice Plans Selected for Case Studies

	Study #1	Study #2	Study #3	Study #4	Study #5	Study #6	Study #7
Communications and plan goals	pp. 47-50			p. 83			
Level of collections	p. 45			p. 83	pp. 94-95		pp. 113,117 119
Roles, responsibilities and administrative relationships		pp. 59-61	pp. 68-69		pp. 94-95		p. 115
Restrictive or onerous administrative procedures		p. 60-61	p. 69,70				pp. 115,116 117-118
Financial reports			p. 68		p. 94		pp. 116,120-122 122-123
Possibility of encroachment on plan revenue by entity above school				p. 83			p. 120
Application of plan rules		p. 59-60					p. 121-122
Plan overhead	p. 45				pp. 94-95		
Distribution by earning units to non-earning units					p. 95		
C. Plan Acceptance by Both Administration and Faculty as Perceived by Site Visit Team	poor	moderate	good	good	good	good	poor

Basic Practice Plan Characteristics

From the diversity seen in the description of the seven medical schools, one would expect the practice plans to be quite different. Their heterogeneity is seen in Table 1, and amplified in the following discussion.

A. Organization - Legal Structure

The structural form that a practice plan takes in public medical schools is often rooted in State law or is tied to other external forces outside the control of the school. Even with private institutions, the corporate form of the plans frequently must follow State dictates. Moreover, Federal law and policies, e.g., taxation, third party reimbursements, influence the structure of a plan. Since policies and laws do change, the form of a practice plan governed by them is forced to change, sometimes drastically.

The AAMC's publication, Medical Practice Plans at U.S. Medical Schools, A Review of Current Characteristics and Trends (Vol. I), reported on the primary features of practice plans operational at 67 U.S. medical schools. The study suggested a way for classifying medical practice plans.[2] One key element in the typology is organizational structure. This typology (Table 2) held that plans could be grouped along a centralized/decentralized axis. Type A represents the centralized extreme where the plan is a discrete recognized entity - either within or outside the medical school - but having its own staff, budget and procedural guidelines. At the opposite pole, Type C characterizes a decentralized situation where a variety of clinical practice arrangements for the academic departments or medical specialties are permitted. The intermediate grouping - Type B - depicts the case where considerable discretion is granted to the department or specialty, but under a centralized framework.

Of the seven plans intensively reviewed, three are designated Type A, three Type B, and one Type C. Six of the seven are organized under the medical school. The one that is outside the school was established as a for-profit corporation at the initiative of the faculty (Case Study #5). It is governed by shareholders who are the clinical department chairpersons.

TABLE 2

MEDICAL PRACTICE PLAN TYPOLOGY

PLAN FEATURES	TYPE A Centralized ←	TYPE B Intermediate ←	TYPE C Decentralized
Organization & Participation			
* Structure	A discretely recognized entity, either within or external to the medical school, having its own personnel, budget and procedural guidelines.	A common framework for clinical practice activity exists within which departmental or specially groups function.	A variety of clinical practice arrangements for academic departments or medical specialties are permitted.
* Policy Determination	All practicing clinicians are included and directly and/or indirectly through their representatives meet with institutional officials to focus only on clinical practice - related issues.	Most clinical disciplines are participants in deliberations about clinical practice - related issues identified by institutional officials.	Executive faculty and the dean consult as necessary during the routine conduct of general meetings.
Operations			
* Administration	A full-time manager supervises the day-to-day plan operation with responsibility for all administrative services supporting the practice of medicine.	A member of the dean's regular administrative staff is the locus for coordination of many plan support services.	Either the department head or his designate directs administrative support services.
* Fee Handling	All clinical practice related revenue flows through the Plan Office which renders bills, collects fees and disburses income.	Uniform procedures for billing, collection and disbursement of fees are implemented.	Options for billing, collection or disbursement of fees are available to academic departments or medical specialties.
Private Medical Schools	12	10	3
Public Medical Schools	21	16	5

The original inception dates for the seven plans range from 1958 to 1973. One plan (Case Study #4) was in constant operation for fifteen years without major revision. Except for two recently developed plans, all have undergone major revision since 1974.

Practice plans take a particular form from the outset or they evolve over time either because of external forces or as a result of internal pressures. A frequent progression is for an institution without a controlled plan at all, i.e., full-time faculty permitted unlimited practice and income, to take on the characteristics of Type C. Gradually, it will move to Type B as pressures for more centralized control build. Sometimes a strict plan is imposed suddenly where no plan existed before. Under such circumstances, either chaos erupts at the institution or the plan quickly moves to a more liberal Type B structure.

With respect to the seven plans reviewed in-depth, the following can be said:

- In one instance (Case Study #1) State legal considerations regarding fee-splitting and local tax rulings were the forces which influenced plan evolution from a somewhat laissez faire approach to partnerships to medical school control.

- The plan described in Case Study #2 evolved from a situation where there was total absence of controls over faculty earnings to one where although there are earnings controls, each department is permitted to establish its own legal structure.

- Income tax considerations and the wish for complete faculty control over patient income were the dominant forces in the development of the for-profit corporation (Case Study #5).

- The presence of a faculty union and collective bargaining in yet another institution (Case Study #6) was the influencing force at one stage of this evolving plan; however, an unfavorable IRS tax ruling shifted the plan's structure from a non-profit corporation to an unincorporated entity within the medical school.

- As far as the other plans are concerned, the initial legal structure has remained unchanged; revisions to the plans have dealt more with plan operations, e.g., billing and collecting.

B. Organization - Administrative Structure and Membership

A formally constituted steering committee for the practice plan exists at least on paper at all seven institutions site-visited. Two of the governing bodies exist as managerial bodies with specific policy-making authority; the rest are advisory to the dean or higher level. In one instance (Case Study #1) an advisory committee is provided for, but has been inoperative. In the majority of cases, each clinical department is represented on the governing body, and interviews with the faculty at these sites evoked no strongly expressed concerns over this aspect of plan administration. In two institutions where the committees were either not representative or not functional, there were serious concerns expressed by many of the faculty interviewed.

Some practice plans have been criticized for being structured in such a fashion that a particular individual or subgroup, i.e., medical specialty, dominates the design and conduct of the plan. For example, the Chairman of the Professional Board at the school represented by Case Study #7 has served in that capacity for several years and, as a result, has established a power base. The plan's by-laws do not provide for turnover in the chairmanship of the governing body. Further, at this same institution, membership on the Board is proportional to the size of the clinical faculty in each department. The five-member Supervisory Board associated with Case Study #2 is comprised of only three faculty (two clinicians) elected by the Executive Committee of the Faculty Board.

Five of the seven plans reviewed have central plan offices and full-time managerial staff. The most significant task for these central offices is the billing and collecting of patient generated fees. Because of the growing complexity of patient fee management and various tax and legal considerations, and because of the increasing significance to the medical school of income from this source, there has been a sharp increase recently in discrete practice plan business offices. A faculty group practice is recognized as a unique activity

within an academic medical institution. Accordingly, the person in charge of the business aspects, it is generally felt, should be specially trained in group practice management.

Because of the relative departmental autonomy afforded by two of the plans, and specifically because of the absence of centralized billing and collecting, a central business service has been regarded as unnecessary.

With respect to membership obligations in the plans, only one of the seven does not require its full-time faculty practitioners to be members as a condition of employment. In this instance (Case Study #2), one department chairman has successfully resisted including the practice of his faculty under an institutionally imposed plan.

C. Plan Objectives and Self-Evaluation

Most written practice plans, usually in the introductory section, state the specific goals around which the plan is designed. These are intended to support the major principles and aims of the medical school which are often more generally expressed. Of the seven study plans, five have written objectives which are specific. In one instance the objectives, though unwritten, are thought to be generally recognized by the administration and faculty; in the other case, plan aims are neither written nor appear to be well understood. In fact in most instances, even though the goals are stated in the written plan, there is evidence that their communication to the faculty is poor.

The most commonly stated plan objective is the attraction and retention of quality faculty through the provision of acceptable compensation levels not achievable through other salary sources. An additional objective quite prevalent among the seven plans is the use of plan revenue to help achieve departmental and schoolwide program enrichment with stable, flexible funds. Aside from stressing monetary advantages, these plans emphasize the objective of enabling physicians to maintain their skills as practitioners so that they can be made available to patients in a quality health care delivery environment. It was disclosed on two site visits, however, that there is some faculty discontent that the plans focus too much on administrative matters to the

exclusion of improving the quality of patient care.

As far as self-evaluation is concerned, with one exception, the plans reviewed have no formal system for assessing the plan's performance against stated objectives. Rather, the common practice is to consider plan modifications irregularly as the need is felt or as crises occur. Each plan has a means of amending its written form, and this process is usually participated in broadly by the plan's membership.

The one plan which does provide for regular plan review (Case Study #2) does so through its governing body on an annual basis -- according to the written plan. In actuality, however, this responsibility is taken somewhat casually, and because of the very small Board, opinions do not represent the total practicing faculty.

D. Practice Setting

In six of the seven plans under study the plan members are restricted to practice in university-owned or affiliated facilities. At six institutions, the primary teaching hospital is owned or leased; in one it is an affiliate. By and large teaching patients at all of the schools are indistinguishable from private patients.

The nature of the practice setting in several of the studies was either a very serious issue at the school, or at least a minor irritant to some of the faculty interviewed. The grim inadequacy of central patient care facilities, for example in Case Study #7, which has existed a long time, has brought this institution to a very serious management crisis. Although less serious with Case Study #1, the scattered nature of practice sites at this institution has contributed to a system of very weak control over billings and collections and less than satisfactory services rendered by the central plan business office.

In no case among the seven plans studied is the arrangement designed - nor the facilities provided - to demonstrate quality health care delivery. The plans are more billing and expenditure control mechanisms than object lessons in group practice. This particular point was stressed by several faculty (Case Studies #1, #7).

The character of relationships between full-time clinical faculty and community physicians was identified

as an issue at two of the institutions visited. In one instance (Case Study #1) the provision of services, e.g., malpractice coverage, to the volunteer faculty member using the clinical facilities of the school and without payment from him, was criticized by some of the full-time faculty. At another institution (Case Study #3) the increasing scarcity of beds in the primary teaching hospital, was felt by some as straining the "town and gown" relationship.

E. Fee Management

The traditional fee-for-service system was found to be the practice at the seven sites visited; no experimentation with prepaid health plans was apparent under the governing medical service plan. As to the highest level where fee schedules are approved, in three instances the plan committee has this responsibility, in two cases the individual departments have that authority, and with the other two plans it rests with the individual physician. It is very common nationally that the practice plan grants the individual practitioner the prerogative of discounting or waiving the patient charge. In only one of the seven case studies is that authority at the departmental level.

Of all the administrative issues and problems observed at the seven visited institutions with respect to their practice plans, those concerned with billing and collecting have caused the most vocal reactions. Three of the seven plans reviewed provide a completely centralized service; two plans let the departments handle this function; and in the other two cases there is some semblance of a centralized service through the plan office, but in many instances at these two schools, there appears to be confusion over billing and collecting with individual physicians unsure what their responsibilities are. The problem can be illustrated by example (Case Study #1): charges are set by the physician and sent to the central plan office for recording and mailing. The payment goes to the doctor who turns it over to the plan office. This office sends only the initial bill unless the physician instructs it to send a followup bill. There is a complete double bookkeeping system since each practitioner "keeps book" on the central business office. There are unsatisfactory cash control, mounting accounts receivable, and inadequate policies regarding uncollectibles. Moreover, since each doctor sets the fee, collects it, files the insurance and keeps books on everything, he asks,

with some justification, what service he is paying for in the central plan office.

F. Income Distribution

The most frequently stated purpose for having a practice plan is to enable the medical school to offer financial inducements to attract and retain capable medical educators. It follows, therefore, that faculty compensation, which includes salary and fringe benefits, is by far the largest item supported by practice plan income. This was evident at the seven schools site-visited. At five of the institutions, the practicing faculty sign annual employment agreements which indicate the salary components.

The association of faculty compensation by source and faculty effort by activity was reviewed in the first year of the Study of Medical Practice Plans.[3] A direct relationship between faculty involvement (percent of time spent in major areas of activity) and sources of faculty compensation was found to exist at 40 percent of the public medical schools and 52 percent of the private schools. As to the seven plans reviewed in depth, four represent schools where the relationship was identified. Two of the plans were designated Type B, one was Type A, and the fourth was Type C. There appears to be no connection between plan classification (AAMC typology) and the relationship between faculty activity and compensation source.

Except for one school, compensation for practicing faculty is on a geographic full-time basis, i.e., total earnings for an individual are influenced by level of patient care activity and the funds he or she is responsible for generating. In these cases, the institution provides a base, or guaranteed, salary component, some of which may include funds generated from patient care. Additionally, there is a supplement or incentive in the form of bonus payment, which in most cases is controlled either through absolute ceiling or progressive taxation, i.e., the more an individual generates, the less is the proportion he realizes as personal income. Only one of the seven schools has an unlimited individual incentive; five have some variation of an absolute total ceiling (one - Case Study #5 - uses a sliding scale).

A strict full-time compensation system holds

that a clinical faculty member's total compensation is in effect guaranteed and not influenced by practice plan income. The single school operating on this basis (Case Study #4) is re-evaluating its very conservative incentive plan, an arrangement seen by many of the clinicians interviewed as providing little personal reward for initiative in patient care.

The customary practice for most medical service plans is to support "off-the-top" from gross receipts the cost of the plan's operating, e.g., billing office, insurance and legal fees. Sometimes total cost is supported in this fashion; in other instances a fixed percentage assessment is made against the gross which may or may not cover those overhead costs. A striking observation was the extent to which faculty practitioners are provided services such as malpractice insurance, space and staff support without paying their full cost either directly from their collections or indirectly through an overhead assessment. Under three of the seven plans such costs of practice are absorbed partly or totally by the medical school of the teaching hospital.

At some point in the income distribution scheme, funds usually are channeled both to the medical school dean for his discretionary use and to the earning department. This is the case for all seven plans in this study. The amount from this source can be quite significant and can help to provide a balance among the school's programs and departments, including the basic sciences. A number of interviewed faculty, for example, were appreciative of a system which was designed to compensate those who are capable teachers or researchers, but who have little opportunity for patient care.

The form and content of financial reports showing the status of collections by individual and by department and the way these reports are communicated by a central plan business office was found to be a problem at three of the schools studied. Either they were non-existent, quite sporadic, or overly detailed with little attempt made to instruct the physician as to how to interpret them.

G. Prominent Issues Identified by Interviewers

Table 1 shows the more prominent issues and concerns which surfaced during interviews with the faculty and administrators at the seven schools site-visited. Also

shown on the Tables is the reference location where the problem is more fully discussed in the respective case study.

Again, matters relating to such financial operations as billing and collecting, fiscal reporting, incentive formulae and plan overhead assessments were the most vocally maligned. There was an additional issue raised, also financial in nature, which pertains to the way states appropriate funds to their universities and the medical schools, the relationship of practice income to the appropriation, and the expectations of adherence by full-time faculty to state rules and regulations. With Case Study #7, a legal battle appears imminent over this issue, the consequences of which may have significant import upon plans elsewhere in the nation.

Other than those which are financially related, a general issue which is apparent to varying degrees in most of the schools site-visited is one of inconsistent or generally lacking communications between school administrators and plan members. Sometimes the practice plan's goals are not adequately expressed, especially to new faculty members. At other times, the composition of the plan's steering committee, the regularity of its meetings, notices and minutes - or absence thereof - are communication factors which lead to poor morale.

H. Typology as an Indicator of Plan Success

Table 2 (p.14) displays the major organizational and operational aspects of a practice plan and describes these attributes along a centralized - decentralized axis. Four characteristics are presented - structure, policy determination, administration and fee handling. In general, a Type A plan is more formally structured as a discrete entity either within or outside the medical school; the plan's advisory committee is more representative of the plan membership; full-time staff administer the plan; and billing and collecting is centralized above the department level. The Type C plan, on the otherhand, is characterized by the existence of a variety of organizational patterns among the clinical department plans; advisory committees are either non-existent or operate very casually, usually with a minimum of faculty in involvement; administrative tasks place at the departmental level; and billing and collecting arrangements vary depending on the wishes of the department or medical specialty. Type B plans fall between these two extremes.

It might be easy for some to conclude that plan success relates to plan type. Intuitively, a Type A structural plan - where the ground rules are spelled out explicitly and where faculty has an opportunity to influence policy - could lead one to judge the plan successful. However, it could be countered that such a plan is overly autocratic and that the Advisory Committee is too large for effective action. By the same token, one might conclude that a loosely structural framework of departmental arrangements, as exists with Type C plans, leads to an unsuccessful institutional practice plan. Yet such a decentralized plan could result in satisfied departments and faculty.

On the basis of the in-depth reviews of the seven plans in this study, typological designation is not a reliable indicator of plan success. The single plan (Case Study #6) which appears to be most successfuly, i.e., have the fewest problems, is classified as Type B; the two plans which have the most difficulties are also Type B. With that designation, one might presume that the pitfalls suggested with Types A and C above could be avoided. Rather than associating a plan's success with the degree of centralized administration which it manifests, one might better relate it to such operational aspects as: (1) frequency and nature of communications between plan administrators and plan members, (2) type of faculty incentive arrangements, (3) clarification in the written plan of roles and authority limits, (4) effectiveness of billing and collecting mechanisms, (5) the character of services in support of practice and how these are costed and charged.

Case Study Summaries

Case Study #1

This Type B plan at a private northeastern school is defined by a series of documents; a complete written plan does not exist. Management is centered in the plan office, but several departments and specialty groups perform plan-like functions autonomously. An advisory committee is provided for within the plan-defining documents, but it has not been functional until recently.

Mandatory membership includes all full-time clinical faculty whose annual employment agreements identify a base salary and incentive component and stipulate the

general rules of the plan.

Monies for the base or institutional salary are derived from the school's general funds, hospital funds, grants, practice revenues or a combination of those elements. The incentive component is subject to a ceiling, but formulae for computation of the ceiling vary from department to department.

Administrative cost to departments for which the plan bills and collects is 25% of collections. An additional 5%, which is credited to the generating department for research and development, is assessed for institutional development. A few departments which do their own billing and collecting do not pay the 25% administrative costs but do contribute the 5% institutional development component to the plan.

The site visit team identified problems of communication between plan administrators and clinical faculty. These may have arisen as a result of turnover of academic leaders and the lack of activity of the faculty advisory committee. The assumption of leadership by the plan's business managerial staff has prompted criticism by the faculty. Such criticisms centered around inefficient, poorly controlled billing and collecting procedures.

Other areas of concern by the faculty interviewed were the relationship between volunteer faculty and the plan, interdepartmental inconsistency of incentive determination, and lack of a clear definition of plan objectives.

Case Study #2

The practice plan at this urban-based public institution in the Northeast was initially established two decades ago, following a period when faculty were permitted to practice for fees under arrangements that did not allow for adequate control. Supervisory management of the practice plan is assigned to the Dean of the Medical School, and a five-member Supervisory Board (including the Dean). Not all clinicians are participants. Most clinical departments have formed corporations, but some are organized as partnerships, and others permit solo arrangements. Billing is not centralized. The plan is categorized as Type C.

Department Chairmen recommend, Dean and Chancellor

approve faculty compensation - basic salary paid from State funds, plus "overpractice" income from the practice plan. The plan permits additional incentive income as approved by Dean and Chancellor to be paid from the plan's earnings (after expenses, overpractice income, fringe benefits, and the departments' and Dean's Fund participation in the earnings). This year the plan is expected to yield $6 million in total revenue. Of this total faculty income from allowable "overpractice" and incentive may approximate $2.6 million, the departments' development funds may receive about $1 million, and the Dean's Fund $500,000.

It was generally agreed by the faculty and staff interviewed that the plan provides the means for attracting and keeping faculty, since State-provided salaries are not competitive; the plan assumes control over faculty time to assure required involvement of the faculty in the School's educational, research, and service objectives. Some aspects of the plan in operation need modification, requiring more specific involvement of the Supervisory Board.

Case Study #3

The practice plan, categorized as Type A, at this urban-based private institution in the South was formally adopted in 1975 as a set of by-laws and has been modified since adoption to reflect changes in the administrative organization of the institution. Fee for practice was permitted prior to the plan's adoption, but the arrangements then in force permitted some excesses which the present plan has corrected. Administrative authority is delegated to the Vice-Chancellor for Medical Affairs, with the Dean of the Medical School controlling faculty compensation and the Medical School budget. The plan operates through the clinical departments; fee billing and collecting is centralized (except for one department) under the plan's business manager who reports to the Vice-Chancellor. A governing committee advisory to the Vice-Chancellor meets monthly to consider policy questions, review plan's budget, and serve as a forum for plan participants.

This year the plan is expected to yield about $10 million. Fees earned by the 175 full-time clinical faculty participants are paid over to the institution; ten percent of the gross collections cover business costs; 10 percent is paid into a trust fund shared equally by Vice-

Chancellor and Dean to provide resources for strengthening the institution, and 80 percent is divided between the department and faculty, under arrangements stipulated in the plan or approved by the governing committee. Faculty receive a stated salary, agreed upon by department chairman and Dean, to be paid from the resources (including the department's share of practice fees) available to the department. In addition, participating faculty receive an incentive income drived from practice, as determined by the faculty member, department chairman, and Dean.

General satisfaction concerning the plan's operations was expressed by faculty and staff interviewed; the plan has provided needed resources to strengthen the institution and to attract and keep faculty in tune with the institution's objectives in education, research, and service. Further improvement in the plan's business operations is expected, and an on-going review of the plan's operations may provide recommendations for changes to assure continued responsiveness to faculty and institutional needs.

Case Study #4

This case study concerns the plan in operation at a long-established, public medical school which is university-based and the only medical school in the state. The plan falls under Type A of the AAMC classification for the study of medical practice plans.

The primary features of the plan are: (a) all full-time faculty licensed to practice medicine must participate as a condition of employment; (b) with a few specific exceptions, all fees generated by the professional activities of the participating faculty must be turned over to the plan; (c) by state law, the plan's revenues can be used only towards augmenting the base salaries of the clinical and basic science faculty over the levels permitted by state and other funding. The net income generated each year by the plan is allocated to: (a) supplement state general revenue appropriations that support medical faculty salaries; (b) augment guaranteed base salaries and fringe benefits for medical school faculty; (c) provide an incentive distribution to the departments that generate the income which can be disbursed as additional compensation to their full-time faculty in accordance with institutional guidelines and departmental formulae.

Although the plan is under the jurisdiction of the state, it is administered by the Dean, with the advice of a committee elected by the faculty, and with the assistance of a full-time plan manager. The amount available as departmental incentive distribution is determined each year by the Dean, in consultation with the advisory committee. Those determinations are based upon accrued balance in the plan's fund, cash collections, cash deficits, fiscal year expenditure, and revenue budgets.

The plan's written components are scattered among state statutes, University Board of Regents governing policies, Medical School's policies, and Committee guidelines. The features of the incentive component vary from year to year and are only vaguely defined.

The plan has been instrumental, since its inception in 1959, in allowing the school to raise salary levels to competitive standards, and has permitted institutional growth and the maintenance of quality programs.

Although administrative improvements are constantly pursued, the faculty are not entirely satisfied with the system. They resent their lack of control on how the money is spent. The principles on which the plan is based are tied to state statutes, and therefore it is unlikely that substantive changes will occur in the near future.

Case Study #5

Governed by a Board of Trustees appointed by the Governor, this free-standing, public, Health Science campus is relatively young. Located in an urban setting in the midwest, the practice plan is categorized as Type A.

At the initiative of the faculty a practice plan was organized only a few years ago for the purpose of generating additional financial resources for improving recruitment and retention of faculty, and to permit the school to reduce its commitment to faculty salary support.

A for-profit corporation has sole jurisdiction for the billing and collection of all practice related income and its disposition. The corporation is governed by sharedholders who are the clinical department chairmen. The shareholders elect a separate Board of Direc-

tors consisting of themselves, the Dean of the College (ex-officio), one elected physician from each clinical department, and others selected by the shareholders. Shareholders have the option to remove any director with or without cause at any time.

Day-to-day operations are handled by a Business Director and 18 FTE employees, who are employed by and report to the corporation's directors. A centralized billing and collection system obtained revenues of #3.2 million last year from the patients of 325 eligible participants; unbilled accounts approximate $2 million. Membership is essentially mandatory for full-time faculty (80) and optional for part-time faculty, and practice is limited to the school's owned and affiliated hospitals.

Collected revenues are credited to the individual earner. Faculty compensation is composed of a base salary, base supplement and an incentive payment. The base salary and base supplement are negotiated between the Dean and the Department Chairman; the supplement is paid only if earned by the physician. Earnings are credited when collected, even those earned in past years. Ten percent of the amount paid to the physician funds a pension plan, and an overhead assessment of 33% is made against gross earnings for the operating costs of the corporation, a Deans' Fund and a departmental account.

The resources generated by the plan have enabled this young institution to develop more rapidly than it otherwise could have developed, and the plan seems to have the general support of the administration and department Charimen. However, other faculty participants voiced criticism relative to billing, collections and inadequate reporting, and some objected to the control, distribution and use of the funds.

Case Study #6

This case study concerns the plan in operation at a long established, free-standing, public medical school in the East. The AAMC classification is Type B.

The plan has written by-laws and procedures approved by the Board of Trustees and has been in operation nearly twenty years with minor modifications. The plan provides that each clinical department will bill for and collect private income for patient services rendered by all physicians holding a faculty position and who receive a base

salary from the institution equivalent to 35% or more of a full-time salary for that rank. Funds are deposited in a discrete departmental bank account.

There is an overall Governing Board consisting of an elected representative from each of the sixteen clinical departments. (With one exception these representatives are the Department Chairpersons.) In addition there is one generally elected representative from the basic science departments. The President of the Medical Center, the Dean of the College of Medicine, and such other officers designated by the President serve as ex-officio members.

The Governing Board establishes standards and procedures for the Medical Service Groups consistent with the policies of the institution and its Board of Trustees. It receives an annual budget and financial report from each practice group and employs a public accounting firm to audit the records of each group. These reports are made available to the President of the Medical Center, or his designees, and all of the records of the practice plan are available for inspection. There are 200 physicians eligible for participation in the plan and the last full year of operation generated $8.6 million. Practice is limited to the University or affiliated hospitals. Each department establishes its own schedule of fees.

Disbursement of funds from the departmental bank account can be made in accordance with the approved budget and within approved policies. These are: five percent of gross income to a central fund for the benefit of the medical center, administered by the President or his designee; reimbursement to the hospital for costs incurred relative to private practice; payment of all other costs of clinical practice allowable as a deductible expense under Federal internal revenue service guildelines; salary supplements as recommended by the deparment chairman and approved by the Dean and President, not to exceed 75 percent of the maximum base salary for that rank; and additional fringe benefits on the amount of the supplement paid.

The service groups are not entitled to hold property and all unexpended funds at the end of each calendar year are paid to a foundation which establishes a restricted account, administered by the College, to be used for departmental development.

The administration and faculty have worked together to reduce interference by a state bureaucracy. They have avoided a central billing system, which they believe erodes the ability of the physician to have involvement with his patients and their accounts. Considering the number of separate accounts, the institution has good total accounting and knows the disposition of all money. The overall plan has enthusiastic support of both administration and faculty and there was no expressed desire to make any significant changes in the plan of operation.

Case Study #7

The subject of this study is a plan of fairly recent origin for a State medical school serving a large inner-city, underprivileged population in the northeast region.

Although the plan falls under Type B of the AAMC classification, it was designed and remains in an interim form because of the temporary state of patient care and teaching sites. Faculty maintaining offices some miles from the Medical School will soon be consolidated in new and renovated central facilities.

The principal features of the plan are: membership is obligatory for all full- and part-time faculty licensed to practice in the State; a central administrative framework with a committee structure; and an optional central billing and collecting system. Considerable departmental independence exists to design distribution formulae after providing for mandated assessments for overhead and for a Dean's Fund. Salaried compensation is in most cases comprised of (1) an academic base which follows a State schedule according to academic rank, (2) a clinical supplement, part of which may come from practice earnings accumulated by the department and negotiated annually, and (3) an individual incentive based on departmental formula. The base, supplement and incentives together cannot exceed twice the maximum academic base salary possible on the State scale for the particular rank.

A recent ruling from the State Attorney General's Office solicited by the institution's administration has made it clear that the plan is a "creature" of the State and subject to its rules and regulations. This has aroused bitter controversy between clinical faculty and administrators over the extensive ramifications such a ruling has on administrative practices. Affected are

personnel hiring and compensation, purchasing procedures, outside bank accounts, financial reporting and audit practices. Should the present polarized views continue, a legal battle could ensue, the consequences of which might have significant impact upon present faculty and upon plans elsewhere in the nation.

GENERAL CONCLUSIONS

Several conclusions can be advanced at this point based on the two-year study of practice plans at U.S. medical schools. External and internal forces at work in the evolution of the respective plan, the functional processes and how they interact, and the assessments of the administrators and clinical faculty at each of the seven institutions site-visited were all addressed during Phase II. What the visiting teams found there and during countless discussions at various meetings and seminars during the course of the study reinforces the following conclusions:

1. The importance of an organized written medical practice plan universally applied to all practicing full-time clinical faculty in a medical school is becoming increasingly recognized nationwide. This is a consequence of the schools' desire to compete in the marketplace for quality, satisfied faculty; to achieve program control and balance; and to counteract the diminution of other significant income sources.

2. Careful attention to the way it is written, reviewed and updated is critical to a smoothly functioning practice plan. The document should include details on the plan's steering committee and how it operates; clearly defined institutional objectives, guiding principles, and plan goals; definition of individual and committee roles and authority bounds; faculty and administrators' rights and obligations; and a clear description of fee handling, compensation elements and income dispersal.

3. It is unfortunate that most plans, even the well-written ones, do not provide for nor carry out a systematic self-review and evaluation process. Rather it is done episodically as difficult problems or institutional crises occur. Sometimes the plan is forced into review by external forces. For example, the Liaison Committee on Medical Education, during their accreditation site visit, may note problems with the practice plan.

4. Although financial matters are important in the operation of a medical practice plan, it seems with most plans there is an over-preoccupation with the "dollar sign."

5. The primary use for income from practice plans has continued to be the support of clinical faculty compensation. This is evident with the seven plans studied, which illustrate a variety of compensation schemes. The importance of individual incentive arrangements is seen. Only one of the seven plans provides little personal reward for initiative in patient care.

6. Although the primary use for plan income is support for clinical faculty salaries, an increasingly significant purpose is financial coverage for broad programs throughout the medical school via departmental enrichment funds or deans' discretionary funds.

7. Very often faculty practioners are provided services such as malpractice insurance, space, and support staff without paying their full cost either directly from their collections or indirectly through an overhead assessment. Such costs are absorbed by the medical school, the teaching hospital or both.

8. Greater flexibility in the use of practice plan revenue has become essential in meeting the program commitments of all medical schools. This is especially true of public institutions where state regulations have become overly restrictive and onerous.

9. Inadequate or widely dispersed physical facilities for ambulatory care are felt to be major problems at some schools and as a result contribute to lax administration and weakened control over the faculty in their patient care activities. Well-planned practice areas that are geared to an efficient operation can attract patients, make practice more palatable to the faculty member and make him more productive during the time he allocates to practice.

10. Although relationships between full-time clinical faculty and non-faculty community physicians

can and do become strained for varying reasons, a practice plan can provide a useful mechanism for achieving a referral policy more favorable to the school. A well-developed plan can attract faculty with excellent clinical reputations, an inducement to more referral patients.

11. In the context of a practice plan, and especially with one newly developed where none existed before, moderation, gradualism and compromise may be the best way to achieve a workable plan and to avoid institutional trauma in the process.

The nature and operation of medical practice plans has for two decades been of vital interest to medical school administrators and faculty. The subject is today especially important, in the face of drastically and suddenly shifting medical school resources. The topic is expected to be debated at length as faculty and medical school administrators strive to satisfy their own objectives as Federal and state pressures for more openness, cost control and accountability grow.

CASE STUDIES OF SEVEN MEDICAL PRACTICE PLANS

Case Study #1

A. Institutional Characteristics Relevant To The Practice Plan

This private northeastern institution is in a densely populated urban setting where there are a large number of patients with a variety of illnesses. There is a relatively small undergraduate medical enrollment, but a very substantial number of house staff. It is the aim of the medical school to help students develop a sense of social commitment by their exposure to a variety of practice settings. The significance of research is also stressed, not only to advance medical knowledge, but also for its value to the learning process.

The school is only one component of a large medical center where there are six major clinical affiliations. The largest hospital affiliate as to bed complement, although separately incorporated, is contiguous to the medical school, and provides the setting for about 75% of the clinical teaching. It has over 1,000 beds, and more than 30,000 admissions, 200,000 outpatient visits, and 50,000 emergency room visits per year. This hospital supports about 50% of the clinical faculty salaries, all of the malpractice and most of the expenses of pathology and radiology.

Relative to other medical schools, the number of full-time clinical faculty associated with the center is large. Traditionally, a great number of volunteer faculty also have been available. The latter group has full admitting privileges at the hospital and generates significant hospital revenue outside the practice plan. The full-time faculty is mostly a young, clinically-active group.

The following table presents quantitative indicators relevant to this case study.

TABLE 3

Statistical Data - 1967-1976

	1967/68	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Student*	340	360	360	400	420
House Staff*	320	500+	320+	540	540
Full-time clinical faculty*	180	240	220	240	260
Full-time clinical faculty at Associate Prof. and above*	--	--	80	120	140
Total volunteer faculty*	--	--	820	--	ca 900
Total regular operating revenues**	--	$8,979	$9,823	$14,506	$20,633
Medical practice plan revenues**	$685	$1,750	$2,158	$7,021	$9,288
Sponsored research expenditures**	$7,166	$7,212	$7,629	$10,404	$13,068
Ratio Full-time clinical faculty to volunteers*	--	--	.27	--	--
% of Full-time clinical faculty at rank of Associate Prof. and above*	--	--	39.2%	48.3%	51.2%
% Medical practice plan revenues to total operating revenue*	--	19.5%	22.0%	48.4%	45.0%

* Rounded to nearest twentieth

** Dollar figures rounded to nearest thousand.

+ Fluctuations due to change in source document questions.

B. The Plan - General Description And History

The practice plan at this institution falls into the Type B grouping according to the AAMC definition. Although a complete written description of this plan does not exist, there arereports and documents which adequately describe the pertinent features of the plan. These materials include employment contracts and financial statements.

Prior to July 1, 1967, the professional staff and faculty of the clinical departments consisted of approximately 80 full-time salaried physicians; 30 geographic full-time faculty; and, 1,000 unpaid volunteers. The GFT complement were provided offices within the institution, paid a small stipend (in recognition of their services to the School) and were permitted to practice under letter contract. A ceiling was placed on their income beyond which all revenue reverted to a fund administered by the University. Under this system, however, there were growing legal problems where, under State law, fee-splitting, which this was judged to be, was disallowed. Thus, on July 1, 1967, a medical group was organized as a partnership.

The partnership was dissolved January 1, 1972, because of a number of technical problems inherent in the partnership structure, e.g., it was impossible to avoid double payment by the institution of Social Security and Unemployment Insurance. Further, reimbursement by third party payers became permissible to staff members in an institutional group setting in the absence of a legal partnership. Beginning in 1972, a city unincorporated business tax would have been levied against the partnership, therefore at that time, the plan was changed and took its present form.

The current plan provides general rules applied universally within the institution to control the geographic location of private practice, earning ceilings and patient billing procedures. The departments and specialty groups have some autonomy in use of funds returned to them. All full-time academic practitioners are required to participate in the plan as a condition of employment and in fact must sign annual agreements

to this effect which stipulate base salary and extent of incentive compensation.

The source of the base component may be the school's general funds, hospital funds, grant funds, and/or practice revenues. In addition, there is an "incentive" component, which has an absolute ceiling. Although individual employment agreements vary in specification of percentages, they relate the supplement to a stated proportion of base salary within a stated upper limit. Fringe benefits are calculated on the base.

There is a practice plan office with limited billing and collection functions and accounting responsibilities. The full-time manager, who reports to the College's financial services director, has a staff of 16.

The individual physician sets fees for his services and has the authority to determine courtesy discounts or fee waivers. The net collection rate is about 75% of fees billed. The average monthly statement load is approximately 5,000. Although billing is officially handled by the plan office, collections may be made by the physicians themselves or by their departments, with disbursement then to the plan office.

In most cases individual collections are assessed a total of 35% - 25% to support plan office expenses, 5% for institutional development (split between school and hospital) and 5% for departmental research and development. A few departments, however, rather than pay the overhead, provide for their own administrative needs. The net is generally available for faculty compensation.

The following Statement of Operations for FY 1976 shows recent income and expenses for the plan.

STATEMENT OF OPERATIONS
July 1, 1975 - June 30, 1976
(Figures rounded to nearest thousand)

Income	$9,288
Expenses:	
Earned Faculty Income (Base)	1,816
Shared Fees (Overage Supplement)	3,681
Staff Wages	873
Fringe Benefits	411
Overhead	787
Development Fund-Departments	498
Rentals	366
Outside Services	367
Supplies	246
Alterations & Renovations	147
Utilities	168
Travel	97
Memberships	70
Other	276
Expenses Allocated to Departments as Overhead	(557)
Total Actual Expenses	$9,246
Net Operating Balance-June 30, 1976 -	$42

Malpractice insurance is provided by the major teaching hospital at no cost to the plan participants.

Only within the last few weeks has a plan management Advisory Committee been activated although it has been "on paper" for several years. Composition includes each clinical department chairman, an alternate, and an elected representative from each clinical department. The Chairman is appointed by the Dean.

C. The Site Visit

During two full days interviews of about an hour each were conducted with the Director of the major teaching hospital, the Acting Dean of the Medical School, the Associate Dean for Business, the financial services Director, the Administrator of the plan, and the legal affairs Director. Interviews were also held with the head of the plan's advisory committee (also chairman of a major clinical department) and six additional clinical faculty members who represented Departments of Sur Medicine, Ob/Gyn, Neurology, Pediatrics and Anesthesiology.

The site vistors included a medical school Dean, an Associate Dean for Patient Services and two AAMC staff members. The visiting team was cordially welcomed. All of the interviewees were very responsive to questions and provided their own perceptions and concerns about the practice plan.

D. Key Issues

For discussion purposes a number of noted issues have been grouped by major category.

1. <u>Structure and General Administration</u>

Among the faculty and staff interviewed there was reported to be a general feeling that the plan, as an integral part of the medical school, is in the best interests of the school and its identified objectives. However, any practice plan applied to the activities of faculty practitioners should, according to a number of the interviewees, provide a means for the expression of views as to its administration. The absence of a functioning management committee, when such a committee had been established earlier "on paper" contributed to distrust of administration by plan participants. This is

especially true since, by default, the plan has been exclusively the operational responsibility of business rather than business and academic leadership.

A strong chairman of a large clinical department, newly arrived at the school, will chair the re-activated management committee. He appeared to be dedicated to improving the existing plan and to making it work. At an initial meeting of the committee held in March, problem areas were identified and subcommittees were assigned to recommend solutions. These included overhead charges, billing and collecting, and program issues.

2. Practice Setting and Hospital Relationships

Throughout the interviews the wishful thought was repeatedly expressed that "if only a Mayo environment could be established..." The reference is to a self-contained clinic atmosphere where everything is readily at hand for the ambulatory patient's ease and comfort. Billing and collecting were designed to be in a central locus. In reality, outpatient care is widely dispersed throughout the teaching hospital, a fact which fosters a wish by the departments to control their own billing and collecting. Major renovation and health delivery program consolidation would have to take place before a "Mayo" could be replicated.

Most of the inpatient and outpatient care takes place within the hospital contiguous to the medical school. The practice plan is seen by the hospital Director as advantageous to the hospital since it keeps the "hard money" budget under control by providing support for clinical faculty salaries. (Approximately 59% from such sources as Medicare-Part A.) This share of faculty compensation is for "service" as well as for supervision of house staff who are paid entirely by the hospital.

A number of the interviewees feel a solid move is under way toward a single classification of patients for both hospitalized and ambulatory care. As it stands now both private and referred

patients are present as are staff patients. Because the hospital does not charge the latter type for professional fees, e.g. Medicare Part B, significant potential revenue is lost. Fiscal staff of the medical school have estimated that, with a single private class of patient, income might rise 40-50%.

Extensive ancillary services are available in the hospital for the patients of plan participants; however, less and less use is made of the services partially because the plan's members have the option to use outside labs. One clinician stated that the hospital does not account separately for such services provided to outpatients; such billing is "locked" to inpatient status. There was considerable enthusiasm expressed that the group operating under the plan might take over responsibility for the OPD and the ancillary services, in which case a fee-for-service system would have to be developed.

Malpractice insurance coverage is provided totally by the hospital to all physicians (plan participants and volunteer staff) who treat patients in that setting. This coverage has been on a self-insurance basis since November, 1975. Contributions to the pool have been at the rate of $2.5 million a year, and are, for the moment, generated from third party reimbursements. There was some concern that new Medicare regulations may disallow this practice, and should that happen, much, if not all, the cost would be transferred to the plan. (The new regulations have in fact limited this practice.) One clinician hoped the coverage would remain with the hospital to induce the facility to provide "quality" patient care. Although the plan members see the hospital's coverage of malpractice insurance as an invaluable fringe benefit, some do not quite believe its existence since no official certificate or documentation has yet been provided to the practitioners. (This is understood to be in the works.)

One administrator at the school criticized the complicated and "unnecessarily divisive" system of "chargebacks" within the Center. The school, for example, rents research space for

its clinical faculty in the hospital. Most practice centers at this institution, in fact, are charged space rent by either school or hospital. There is under consideration a department space charge regardless of where it is located

3. Billing and Collecting

Billing and collecting procedures elicited the most outspoken criticism among the interviewed clinicians. The system is as follows: charges for professional services are developed by the physicians, either as individuals or departmental groups; they are submitted to the central billing office for recording and mail out; the bills are rendered in the name of the physician who receives the payment; receipts are deposited with the billing office; when the initial bill is not paid within a reasonable period, the physician or his department makes the decision as to follow-up billing or whether it is uncollectible except through a collection agency.

This system has led to a number of inefficiencies. The institution's outside auditors have criticised the school for unsatisfactory cash control procedures, mounting accounts receivable, inadequate policies regarding uncollectibles, lack of a central cashier, and poor control over the physicians' courtesy discounts and fee waivers.

Adverse comments from the faculty stem partly from distrust that full patient fee processing services are not provided by the central plan office. Many faculty members apparently fear that funds collected from them will not be credited properly to their accounts. Further, they complain of numerous mistakes and inadequacies within the computerized system, which generates excessive data beyond what the physician needs to know on his collections. These concerns have led to widespread double bookkeeping. Plan members are irritated by what appears to them to be an unjustifiably high overhead tax imposed by the central administration. Nevertheless, departments must maintain staff to prepare third party billing. They see the system as cumbersome and impersonal, and to many the only solution is to decentralize the total billing system to the departments.

4. Income Distribution

The rules of this practice plan provide for an "incentive" supplement beyond an institutional base salary. The supplement must be earned, however, and is subject to an absolute ceiling. Although it has been said that fewer than a dozen individuals reach their ceiling, there is general distaste for a fixed ceiling on earnings. The following reasons were given by the physician interviewees:

a. Some of the faculty who reach their ceilings hold back billings until the next fiscal year.

b. It is a recruitment disincentive -- although at present the ceiling is high enough to preclude many reaching it, it does remain as a psychological barrier.

c. As the patient population grows, it discourages the faculty member who is approaching his ceiling from taking on a greater service load.

d. From the department's standpoint, the ceiling's effect on general departmental revenue can be crucial if it leads to curtailed patient billings for those faculty "bumping ceiling."

A number of clinicians interviewed, however, seem to have accepted their own level of "genteel poverty", sacrificing large gains outside the school. To them, the presence of an earnings ceiling means very little. Their focus is more on the academic nature of the institution. In fact, to this group, it is quite legitimate for the school management to use their patient earnings beyond their own compensation in order to help the total school achieve its goals.

There is significant criticism from the administration of the variety of departmental formulae for calculating the individual's "incentive" compensation. The formulae change quite frequently and it may be difficult to recall the rationale for a particular distribution scheme.

Such diversity weakens faculty morale and fosters suspicions of inequity.

The department chairman has great latitude in determining the manner in which his department's earnings are spent for non-salary items. There was some feeling expressed that intra-departmental units should have greater voice in determining the use of the funds they generate.

A major problem relating to salary and fringe benefits was evident during the interviews. Although a broad liberal benefit package now exists within the institution, there are a number of faculty reaching retirement age who started their career at the school when such fringe benefits were comparatively meager and who consequently have accumulated little in their retirement annuity. Long under a geographic full-time system, this school until recently provided token base salaries, while it allowed unlimited retention of practice earnings. Institutional contributions to retirement for individuals with long service would therefore have been relatively little.

5. General Membership Attitudes, Programmatic Concerns and Self-Assessment

This institution has had a long tradition of dependence upon volunteer faculty who have full admitting privileges to the major teaching hospital. Gradually, the small nucleus of full-time faculty expanded, and, as a consequence, the dependence on volunteer staff diminished, but they have nevertheless remained. There was feeling among the clinicians interviewed that such a system of volunteer appointments to the degree it exists today, is no longer appropriate. These views and the reasons for them can be summarized as follows:

a. The presence of large numbers of volunteers subverts development of a good internal medical referral base, as many on the full-time staff refer to non-faculty specialists on the outside. At least one group of full-time faculty

practitioners has the view that the group should function more interdepartmentally, but, because of the lack of internal speciality coverage, they must refer to the outside volunteers. As a result, potential income to the School is lost.

b. With admitting privileges to the hospital and malpractice insurance protection, the volunteers have "free protection" paid by the hospital, and without imposition of an earning ceiling.

Although there was adverse feeling toward the volunteer staff, it was the view of one prominent clinician that this "town-gown" problem should "come to a head" with the appointment of a new dean. He commented that many have good academic potential and, under the right circumstances, some may want to join the full-time faculty.

The fact that the deanship and several departmental chairs have been vacant for some time at this School has led to a conspicuous absence of leadership in many policy making areas including operation of the practice plan. Such a situation appears to have aggravated mutual distrust between business officers and faculty practitioners. Some of the clinicians were viewed as far too "avaricious" and lacking the School's best interests, while the business administrators were seen as eager to "milk" practice revenues so that administrative needs could be met.

Not only did communication between these two groups appear less than ideal, but communication among the full-time practicing faculty also seems to be inadequate in some respects. The new chairman of the plan management advisory committee, in particular, noted this problem.

Knowledge that there are income distribution formula variations among the departments and, within departments, among organizational units, seems to have furthered suspicion of special

privilege, the site visitors observed. Many faculty have no knowledge of the source(s) of their compensation.

To several of those interviewed, a practice plan should reflect more than dollar flows. It is viewed by them as a way to preserve some semblance of program perspective and balance and should include a clearly stated set of objectives. Such objectives are not written at this institution, and a formal self-evaluation process does not take place. Each individual involved with the practice plan has his own view of what the plan is and its purpose, as well as what the plan should be. Frequently, as this site the two focal points -- income generation versus program control -- were found to be antithetical. The views paraphrased below serve to illustrate this dichotomy:

> "It is unfortunate that the plan has become such a major funding source as it interferes with more scholarly pursuits."
>
> "There is a basic problem of maintaining a strong academic environment in this intense practice setting."
>
> "The plan is an important financial operation. It's the only thing that's growing. The institution shouldn't be too greedy about diverting money to institutional support."
>
> "The plan should be a professional, organized health care delivery scheme, taking into account such ideas as prepaid patient contracts."
>
> "The plan should provide a place to practice in the institution and at the same time should make the practitioner feel more a part of academic life -- a natural trade-off would be less income."
>
> "A plan should provide the means to attract and pay for full-time faculty and is an economic device to stabilize school and departmental resources."

"A money-maker for the institution."

"The plan is so structured that it encourages a 'treadmill' of service commitments which are difficult to keep up with."

"Under the plan and its administration, not enough attention is paid to such vital issues as finding ways to improve the pedestrian issues of billing and collecting."

6. Team Observations

During the series of interviews, a number of striking observations came to light which partly reflect individual attitudes as well as conditions found to exist currently at the institution. These are as follows:

a. Search is under way for a new medical school Dean; the Acting Dean has been functioning for less than a year; seven departmental chairs are also vacant.

b. The management advisory committee for the practice plan had, until recently, not met since 1971; it is currently headed by a new chairman of a large, active clinical department.

c. At the initial recent meeting, the advisory committee identified three problem areas for further study by subcommittees: overhead costs, patient billing and program.

d. Duplicate record keeping and redundant accounting procedures are apparent in some areas. Very limited service is now provided by the central billing office.

e. External auditors have been critical of the lack of cash control procedures in the billing operation; the amount of accounts receivable has grown steadily.

f. The Department of Surgery generates about half of total plan revenue.

g. Under the plan, the practitioner is not obliged to obtain laboratory services from the hospital for private ambulatory patients. As a result, there is considerable lost revenue to the hospital.

h. Charges for professional services (Part B) are not rendered for non-private patients.

i. The Acting Dean stated that "the Associate Dean for Business runs the plan."

j. The mainstay of ambulatory teaching - a nucleus of seven faculty in the Department of Medicine - was outspoken in criticism of the presently constituted plan and its operation and had made veiled threats of departure as full-time faculty.

k. Some mistrust by clinicians of the central billing office appears to emanate from an earlier experience in which a responsible administrator from this office was found to have perpetrated fraud.

l. There is physical dispersion of patient care activities throughout the Center which seem to make a central billing and collection operation impractical.

m. Until very recently fringe benefits were associated with the salary base only and the base itself was frequently little more than a token amount of total compensation.

n. There was expressed ill feeling by the full-time clinical faculty toward the large complement of volunteer faculty.

o. Dissatisfaction with an absolute ceiling on individual earnings was widespread, but there was some difference in personal view between the more "scholarly" clinical faculty members and the "pure" practitioners.

p. A recent daily hospital inpatient census revealed that 55-60% of medicine and surgery beds were assigned to staff patients.

7. Conclusion

At this site, the practice plan as it now operates, has led to a number of problems. Most of them appeared to be transitory, the result of large scale staff turnover and vacancies. There appeared to be several possible alternatives for solving the thorny issues relating to billing, collecting and accounting. One positive sign is the reinstitution of the Management Advisory Committee, which is expected to establish regular communications between business staff and faculty practitioners. The majority of faculty and staff appear interested in improving the present situation.

Case Study #2

A. Institutional Characteristics Relevant To The Practice Plan

This ia a long-established urban-based public institution in the Northeast which has approximately 300-member full-time clinical faculty with the interest, time and freedom to promote excellence in patient care, teaching, research, administration, and academic growth. The student body numbers about 1,000 undergraduate and graduate medical students, and approximately 150 pre- and post-doctoral candidates in the basic sciences.

Limited financial resources provided by the State for faculty salaries are not sufficient to attract and keep a body of competent clinical faculty. Arrangements have been made, therefore, for the opportunity for faculty, through private practice, to provide additional resources for their partial support and for strengthening the institution and its individual departments. This private practice takes place only in the University hospital, and in affiliated clinical institutions, under arrangements stipulated in the practice plan.

The table on the following page presents variables over time that are pertinent to this case study.

TABLE 4
Statistical Data - 1967- 76

	1967/78	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Student*	500	540	560	580	680
House Staff*	240	260	300	-	360
Full-time clinical faculty*	180	200	240	220	280
Full-time clinical faculty at Associate Prof. and above*	-	-	80	80	120
Total clinical volunteer faculty*	-	-	280	300	360
Total regular operating revenues**	-	16,643	15,029***	20,226***	17,721
Medical practice plan revenues**	-	1,048	1,423	2,324	5,029
Sponored research expenditures**	4,840	5,526	5,286	5,973	7,905
Ratio full-time clinical faculty to volunteers	-	-	.8	.7	.76
% of full-time clinical faculty at rank of Associate Prof. and above	-	-	35.9%	37.7%	42.9%
% Medical practice plan revenues to total operating revenue	-	6.3%	14.3%	25.0%	28.4%

* Rounded to nearest twentieth
**Dollar figures rounded to nearest thousand
***Added $2,922 of general university funds and $2,151 of hospital - teaching clinic funds in 1971/72 and $4,523 of general university funds and $6,406 of hospital - teaching clinic funds in 1973/74.

B. The Plan - A General Description And History

The medical service plan at this school is classified as Type C according to the AAMC's typology. It was first established two decades ago, following a period when faculty were permitted to practice for fees, but under arrangements during the 1960's that did not allow for adequate administration and central organizational control. Although there were agreed upon ceilings, there was the suspicion of violation of the ceilings because of individual billing arrangements.

The plan was developed by a committee composed of department chairmen, faculty, a hospital director, and a fiscal officer, and approved by the University Regents and the Chancellor. Supervisory management is assigned to the Medical School Dean; there are no by-laws as such, but the plan is in written form.

1. Objectives

The plan recognizes several purposes to be achieved:

- attract high quality faculty to teach, conduct research and engage in patient care
- permit physicians to maintain their skill through practice in addition to the clinical activity necessary for the education program.
- provide means for all departments to develop and to maintain an inter-departmental balance (personnel, space, finances) consonant with the medical school's goals
- enable plan participants to be allowed benefits, such as contributions to retirement systems, health, life, and disability insurance, in addition to those provided by the state

2. Organization

A variety of arrangements are available for faculty who want to participate in the plan. There are some clinical faculty who do not participate, generally concentrated in the Department of Internal Medicine. This chairman has resisted structuring the practice of his faculty under an institutional plan. The great heterogeneity among his faculty as to sub-specialty would also preclude a concensus on plan structure.

Most of the clinical departments have formed corporations, as allowed by State statute in 1972, and their entire full-time clinical faculty are included in the corporate sturcture. These function like a charitable trust under which faculty fees are "donated" tax-free to the non-profit parent institution. Other departments are organized as partnerships, while still others permit faculty to participate on a solo basis. One department, organized in divisions, permits some of these units to form individual corporations, or partnerships, while the faculty of other divisions participate as solo practitioners.

3. Operational Aspects

Whatever the organizational structure, the medical service plan has the following features:

a. Facilities - space and equipment - for the participating physicians to practice are provided by the University Hospital or affiliated institutions, without charge to the corporation, partnership, or solo practitioner.

b. The professional fee income of the participating group includes all the fees generated by the participating members. Each group determines its own fee structure.

c. From the professional fee the following income are deducted:

(1) the ordinary and necessary expenses incurred in earning the income, including the cost of professional liability insurance not borne by the University Hospital (the Hospital pays 60%, the individual pays 40% of the insurance cost)

(2) the additional income, termed "overpractice", permitted to the individual members of the plan over the member's basic salary, and in accordance with the compensation arrangement made each year for each faculty member. This arrangement, recommended by department chairmen, but requiring approval by Dean and Chancellor, determines the basic amount to be paid each faculty member from State funds, and the additional income to be allowed the faculty member from the income of the participating plan (or from other activity, such as research grants)

(3) the cost of fringe benefits in addition to those paid by the State.

d. The balance of the professional fee income is distributed as follows:

(1) 50% to the departments, to be used to pay for departmental research, books, minor equipment, travel, and such other expenses as approved by the Dean.

(2) 20% to the Dean's Fund to be used for institutional and faculty development.

(3) up to 30% of the remaining funds may be paid to the faculty as incentive overpractice income, subject to the concurrence of Dean and Chancellor.

e. At year's end, all remaining professional fee income not disbursed, is paid into the University's account; there is no carry-over of funds from one year to the next for the benefit of the participating members.

f. Each participating group maintains its own billing arrangements, management procedures, and accounting controls; however, the accounts are subject to audit by the University Business Office.

g. A five-member Supervisory Board oversees the plan, and is empowered to make recommendations to the Faculty Board on modifications to the plan, or its continuance. The Supervisory Board is comprised of three faculty (two clinicians) elected by the Executive Committee of the Faculty Board, the Dean, and the Director of the University Hospital. The Supervisory Board according to the written plan is to meet at least four times a year to discuss and review the plan's operations. The Board's review of the plan and change recommendations are to be made to the Faculty Board by October 1 of each year.

4. Finances

Annually, the plan yields about $6 million total revenue. Of this total, faculty income from allowable over-practice and incentive may approximate $2.6 million, the departments' development funds may receive about $1 million, and the Dean's fund $500,000.

The following Statement of Operations reflects income and expenses under this plan for a recent six-month time period.

TABLE 1

STATEMENT OF OPERATIONS

Six Months - Jan. 1 - June 30 1976
(Figures rounded to nearest thousand)

Income (net after inter-account transfer)	$3,132
Expenses	
Salaries (Professional Overpractice)	935
Non-professional Salaries	133
Fringe Benefits & Payroll Taxes	284
Malpractice Insurance	231
Dues, Licenses, Publications & Subscriptions	69
Travel	54
Outside Services	64
Accounting & Legal	25
Office Supplies & Expenses	22
Other	78
Sub-Total	1,895
Distributions	
Dean's Fund	239
Departmental Development Funds	553
Incentive Overpractice	342
Net Operating Balance - Six Months Ended June 30, 1976	- $103

5. Team Observations

A review of the plan as it functions was provided in discussions of one hour each, with the Dean, his Associate and Assistant Dean, the University Director of Business Services, the Hospital Director, the chairmen and plan directors for six clinical departments, and the consultant to the medical service plan.

The following picture emerges of the plan in operation:

a. To-date the Supervisory Board has not functioned as the plan stipulates--few meetings, no plan modifications recommended, and little communication with the Faculty Executive Board. Generally, this was seen by the interviewees as an unfortunate situation. The view was expressed by one clinical chairman who felt that the Supervisory Board, even though meeting irregularly, was "Dean-dominated" and that the less they met the less likely they would disrupt his departmental plan. A general view was that this Board was not as broadly representative of the clinical disciplines nor the rank and file faculty as it should be.

b. Incentive practice income is generally disbursed in the manner decided upon by the department chairman. However, not all plan directors understand that the Chancellor's approval is required of the incentive income allowed participating faculty.

c. The informal arrangement with the Dean for discussion and approval of items that could be included in the cost of practice, leads to lack of uniformity in operations among the groups. Moreover, plan operations differ considerably, with some plans operating with little or no directional input by the Dean, since his opinion is rarely requested

d. The central administrative structure foresees a central billing function. The participating groups prefer the current decentralized system, because of the flexibility it permits in providing the means for the groups to control their funds without close State scrutiny.

In the interim, a set of detailed and extensive accounting procedures and guidelines have been developed by the consultant to the medical service plan. These procedures have not been imposed on the groups, but their development may be viewed as an indication of management's dissatisfaction with the current procedures and controls for some groups. One hoped for result of this manual will be to establish consistency in the treatment of cost of practice items. Further, the departmental groups have been urged to seek outside legal and CPA consultation on billing and collecting, and various Federal tax consequences.

A general consensus also emerged from discussions with various members of the faculty and staff:

- The clinical chairmen were in favor of the plans' continuation; it provides the means for attracting faculty since the State provided salaries are not competitive. There is also general agreement that the incentive income approved by the department chairmen should be awarded to faculty. For some departments this occurs uniformly, with the incentive payments disbursed to the faculty without waiting for the Dean's or Chancellor's approval. Other departments operationally await the Chancellor's approval.

- The overall plan is beneficial to the institution since it assures some control over faculty time to insure the required involvement by the faculty in the school's educational program. Furthermore, there is considerable income disbursed to the departments and to the Dean, providing the re-

sources not available from other sources.

- Individual departmental plans make possible total compensation levels which are advantageous to the faculty. These levels are not considered to be out of line with the total compensation levels provided by similar institutions. The additional fringe benefits are included as cost of practice expense, and are therefore not included as taxable income of the practicing physician. This procedure, however, was the source of expressed concern. The great variations among the departmental benefit packages, which were felt to result from "too many verbal commitments", has led to some dissension. There have been recent efforts to achieve more uniformity.

- One chairman expressed the concern that providing the Dean and the departments with a share of the professional fee income may be construed as fee-splitting, on which no income taxes are paid. The departmental plan director suggested that there does not appear to be a recognition of this possibility by the Supervisory Board. Other directors, however, viewed this sharing of income as payment for the services provided by the Hospital, as payment for the affiliation of the plan with the medical educational institution, and as a contribution to a nonprofit institution.

- The unpredictable nature of total earnings is a concern to some, particularly the more junior faculty.

- Dissatisfaction was expressed with the level of responsiveness by the central campus business office to general academic needs, including those for practice plan operations. Slow processing time and unnecessary and cumbersome purchasing and personnel procedures were cited as examples.

6. Conclusions

Some aspects of the operation of the plan need

modification. More direct and mutual involvement by the Dean, department chairmen, and plan directors is needed; movement toward modification assures its continuance. There is provision in the plan's written description for an assessment to be provided periodically by the Supervisory Board of the achievement of stated objectives of the plan. There is little evidence, however, that this is being executed.

CASE STUDY #3

A. Institutional Characteristics Relevant to the Practice Plan

This is a Southern, urban-based private institution, in its second centennial. A reputation for quality medical education, professional excellence, and dedicated health care has established the institution as a patient referral center for the State, Region, and Nation. The clinical full-time faculty of 260 is augmented by about 400 volunteer faculty; the student body is composed of 630 undergraduate students and house officers and about 200 students in pre- and post-doctoral programs. The University hospital has 500 beds, the clinics have an average of 15,000 visits a month.

Payment for patient care provided by the full-time clinical faculty under formal billing arrangements is a relatively recent phenomenon. The formal practice plan proceeds help to provide the means for the institution to maintain its educational standards by attracting and keeping faculty committed to both quality education and community service; contributing significantly to the institution's current strong fiscal position. Faculty private practice takes place principally in the University hospital, and to a considerably lesser extent in affiliated settings, but all under arrangements stipulated in, or with approved exceptions to, the formal practice plan. The University hospital does not operate as a closed system, but referrals to, and patients admitted by the full-time faculty do predominate, accounting for 85-90 percent of all admissions. The practice group as a formal organization does not have a central patient referral system. The following table presents variables over time that are pertinent to this case study:

TABLE 5

Statistical Data - 1967-76

	1967/68	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Student*	220	240	280	320	340
House Staff*	220	220	260	280	360
Full-time clinical faculty*	100	120	160	240	260
Full-time clinical faculty at Associate Prof. and above*	--	--	80	100	100
Total clinical volunteer faculty*	--	--	340	380	420
Total regular operating revenues**	--	$4,179	$6,756	$9,190	$15,783
Medical practice plan revenues**	$773	$945	$2,658	$3,863	$ 9,686
Sponsored research expenditures**	$5,335	$6,095	$8,006	$8,599	$11,187
Ratio Full-time clinical faculty to volunteers	--	--	.51	.61	.60
% of Full-time clinical faculty at rank of Associate Prof. and above	--	--	44.97	42.30	43.43
% Medical practice plan revenues to total operating revenue	--	22.62	39.34	42.04	61.37

*Rounded to nearest twentieth

**Dollar figures rounded to nearest thousand

B. The Plan - General Description and History

The Institution's professional practice plan is classified as Type A under the AAMC's classification system. Until a decade ago clinical faculty involvement in patient care was viewed as necessary solely for the educational process. Reimbursement for such services was haphazard. It was possible to maintain this situation while fiscal resources were sufficient to provide adequate compensation for the faculty. This changed, however, and the need for drawing upon patient fees to help pay the clinical faculty led to a study by a faculty committee of practice plans in other institutions. The interim plan that emerged from this review permitted considerable variation by departments in the charges for overhead. Moreover, the scheme for the faculty's sharing in the practice income permitted some excesses in disregard of the institution's over-all objectives.

The current plan is written as a set of by-laws, approved by the University Board of Trust in 1975. At that time, the Vice-Chancellor for medical affairs was also Dean of the medical school. The written plan, therefore, in referring to the duties of the Dean in relation to the practice plan, was at the same time referring to the position of the Vice-Chancellor. At the present time there are two officials, a Vice-Chancellor for medical affairs, and a Dean of the medical school. The practice plan responsibilities of each are now clearly delineated in documents and committee proceedings which supplement, but have not been incorporated into, the by-laws of the practice plan.

The University Chancellor has delegated administrative authority of the practice plan to the Vice Chancellor for medical affairs; his function is to assure that collections are properly accounted for, and that operations are appropriately carried out. The Dean (and Department Chairmen) are responsible for the expenditure of funds, other than the amounts allocated to the Vice-Chancellor's trust fund, under the terms of the practice plan, with guidance from the Governing Committee. The Dean has control over the individual faculty member's compensation, as well as responsibility for the medical school budget.

1. Objectives

The plan recognizes several purposes to be achieved:

- Assist in the medical school's growth and development.
- Advance patient care standards in the university hospital and clinics, including the development of improved health care delivery systems for reduction and control of health care costs.
- Enhance opportunities for faculty to conduct clinical research, and provide an adequate patient population for the institution's educational needs.
- Define and standardize the conditions under which the institution's faculty engage in and are reimbursed for professional practice, in accordance with the educational, research, and service responsibilities of the institution.

2. Organization

The affairs of the professional practice plan -- policy, budget and use of funds for construction and renovation of clinical facilities, interpretation of the by-laws and plan provisions, and other matters brought by plan participants -- are reviewed by a committee, which is advisory to the Vice-Chancellor. The Committee is composed of a chairman, all clinical department chairmen, five elected plan participants and two appointed by the Committee chairman. Ex-officio Committee members are the Vice-Chancellor, the Dean, Directors of University Hospital and affiliated clinical institutions, and the plan's Business Manager.

The Committee meets monthly, and the meetings are open to all plan participants.

A subcommittee of the governing Committee has

been appointed to review the operations of the practice plan, and make recommendations for changes.

The plan operates through the clinical departments, with the business arrangements of billing and collecting of fees centralized under the plan's Business Manager who reports to the Vice-Chancellor. There is one department -- psychiatry -- which is permitted to bill and collect fees outside the central system. Also, all full-time faculty who see patients at the two affiliated hospitals bill outside the central system, but turn the collections over to the plan's accounting office.

About 175 full-time clinical faculty, representative of all the clinical departments, have signed the formal agreement indicating acceptance of the plan's conditions. Such a signed agreement is a condition of employment. Practice is conducted by departmental groups, partnerships or solo.

3. Operational Aspects

All fees earned by the plan members are paid over to the institution, and are disbursed in accordance with the features of the plan. In principle, fees for professional services are fixed by the Governing Committee, but in practice, the individua plan member sets the fees charged for services rendered.

Faculty compensation is determined as follows:

> Each faculty member receives a stated salary, agreed to by the Department Chairman and the Dean. Fringe benefits are based upon this stated salary. The stated salary is paid from any resource available to the Department Chairman, including the department's share of practice fees. In addition to the stated salary, the participating faculty member receives an incentive income, derived from practice, as determined by the faculty member and Department Chairman.

In practice, the medical school Dean also approves the amount of incentive income.

Gross collections from practice plan operations are distributed as follows:

- Ten percent is paid to cover the cost incident to the operation of the plan (centralized billing and collecting primarily). Costs by the hospitals and clinics where the practice takes place are borne by the hospitals and clinics, not the practice plan.

- Ten percent is paid to a trust fund, one-half for the use of the Vice-Chancellor, and one-half for the use of the Dean of the medical school, for the strengthening of the institution.

- Eighty percent is divided between department and the individual faculty member. This distribution is not based upon the "productivity" of the faculty member in generating the income. The plan permits variation in the sharing of this residual 80 percent, within specified bounds; the most predominant arrangements provide 20 to 50 percent of the residual income as incentive income. Any other distribution scheme must be approved by the Governing Committee.

- Additional fringe benefits over those based upon the member's stated salary are not presently available, however, the department's funds do pay malpractice insurance premiums.

4. Finances

Currently the plan is expected to yield about $10 million. This School and its center, vis-a-vis the parent University, have assumed full responsibility for income and expense. The collection rate against net billings approximates 80 percent.

C. Team Observations

A review of the plan as it functions was provided in discussions with the Vice-Chancellor, Dean, Hospital Director, Acting Director of Ambulatory Services, Director of Medicine at an affiliated institution, five Department Chairmen, three faculty plan participants, including elected members of the Governing Committee, and the plan's business manager.

The following picture emerges of the plan in operation:

1. A consensus was presented on the openness under which the plan operates, and the opportunity for all participating members to attend Governing Committee meetings and to receive the minutes of proceedings. No objection was raised concerning the confidentiality of faculty income, apparently the sole area of secrecy.

2. It was also generally expressed that the plan provices essential resources to the Institution. General approval was also expressed of the use by the Department and Dean of patient care income to strengthen departments not having such resources and to pay faculty salaries where necessary. It was made clear that the purposes for which the Dean uses the patient care income is not secret. The information is available to any plan participant who requests it, although there is some difficulty in providing the data, since such funds are merged into the general funds budget of the school. Some dissatisfaction was aired concerning the funds made available to the Vice-Chancellor.

3. It was generally agreed that faculty involvement in patient care does dot detract from the essential involvement in education and research. The faculty who have showed a disproportionate attention to patient care at the expense of adequate attention to education and research are no longer at the institution.

4. Financial reports to the departments could be improved, stressing in particular accounts

receivable information in easily understood form.

Differing views were expressed concerning the following:

1. Several chairmen and faculty indicated concern that while the plan by-laws provide for the Dean to control the plan's operations, in fact the Vice Chancellor has this responsibility. Apparently, it is not recognized that this modification of the written plan was developed with the full knowledge of all concerned, and prior to the time of separation of the functions of Vice-Chancellor and Dean, and before a Dean was appointed. Other persons conveyed the impression that this "change" was not disturbing to them, and that the Dean had firm control over the faculty compensation and effort distribution; that the Vice-Chancellor had responsibility for the health center, including the hospital and clinics where the practice takes place, and therefore had a legitimate interest in the plan's operations. It was not generally understood that in the Vice-Chancellor's view, his involvement with the plan's operations will diminish when new university hospital facilities replacing the existing facility are in place, and the central business office is fully functioning.

2. Hospital and clinic resources - personnel and facilities - made available to the plan participants were not always adequate to the needs. The control of the number, salary and fitness of the employee for the position is not exercised by the clinician using the resources. On the other hand, a need was expressed by the hospital director for reimbursement for the use of these hospital resources, with the counterthrust by some faculty that the hospital and clinics, laboratories and diagnostic facilities were fully utilized only because of the patient services provided by the plan participants. It was also indicated that chairmen and faculty could exercise control over personnel assigned to their practice areas by becoming more involved with the university in specifying the unique requirements of the position and thereby gaining exceptions from the University's "procrustean" personnel standards and

business operations.

3. Centralized billing and collecting procedures have improved tremendously over the recent past, characterized by all as "horrendous". Some dissatisfaction is still present, however, with some expression of the advantages to be gained if the individual departments controlled the billing and collecting of fees. It was stressed that better relations with the patients would result than now exist, since the patients must deal with an impersonal office which has no direct contact with them. This is particularly important, we were told, where patients have financial difficulties; the physician or his immediate staff would be better able to make necessary arrangements for payment than the central office.

4. The presence of a "town-gown" problem was viewed differently. One faculty member expressed the view that hospital beds were a critical issue at the institution and as demand increases, volunteer faculty may be increasingly "frozen" out of admitting to a University hospital with a severely limited bed capacity. He further felt that the peer review committee composed of medical school faculty was being unfairly hard on community practitioners. On the other hand, another faculty member perceived a lack of competition between full-time faculty and community practitioners; faculty and non-faculty clinicians perform complementary tasks (at least in his specialty). For his specialty, there is a healthy referral relationship with physicians in the community.

5. One of the persons interviewed strongly expressed the hope that the plan and its Governing Committee would become less preoccupied with such administrative matters as billing and collecting. Should that occur, focus could be shifted to qualitative health delivery concerns, especially the plan's operation of the University Hospital's outpatient facility.

D. Conclusions

Following an experience of trial and error, the current plan appears to be well adapted to the needs of

the institution and faculty. Operational aspects have improved, and indications are that further improvement is near. The Governing Committee provides a forum for grievances. The organization of a recent subcommittee to review the plan and recommend changes offers the possibility for continued responsiveness of the plan -- to improve health care and patient well-being, to advance medical education, and to maintain the institution's prime resource- its faculty.

CASE STUDY #4

A. Institutional Characteristics Relevant to The Practice Plan

The Institution covered by this report is a public medical school, part of a university medical center that includes a school of dentistry, a school of nursing, and programs for training of students in the allied health professions. For the last fifty years the medical center has been located in an urban setting, remote from the campus of its parent university. The institution is the only medical school in the state.

The major clinical facilities available to the Medical School include the University Hospitals (a State General Hospital and a State Psychiatric Hospital), a VA Hospital, a City Hospital, outpatient clinics, and several specialized diagnostic and treatment centers.

The Medical School enrollment includes about 500 undergraguate medical students and 1400students in M.S. and Ph.D. programs of the basic medical sciences. The Medical School faculty is also responsible for the training and supervision of over 500 graduate medical students, and it participates in the teaching of students of other schools of the medical center.

The Medical School faculty numbers about 500 full-time members of which approximately 400 are clinicians. In addition, the clinical departments utilize the services of volunteer faculty members drawn from among the practicing physicians in the region.

The affairs of the medical school are directed by the Dean, in collaboration with the Executive Faculty. The Dean reports to the Chancellor of the Medical Center and

to the President of the University. The University, its Medical Center, and the University Hospitals are goverend by a Board of Regents elected by the voters of the state.

By statute, the Medical School mission is the education of medical students. The school's full-time faculty physicians, through their service in the University Hospitals and clinics, however, play a major role in providing medical care to the indigent residents of the state. The state does not fund the school's research activities, however, a vigorous research effort is supported by funds from other sources.

The governing statutes and the policy of the University's Board of Regents stipulate that indigent persons have priority in the use of clinical facilities. The medical center next accepts full-paying patients admitted by the full-time faculty, who are contractually bound to admit their private patients to the University Hospitals and clinics. All patients accepted within the University Hospitals and clinics are treated on an equal basis, and participate in the Medical Center's teaching programs.

All full-time faculty members of the school are, by virtue of the by-laws and policy of the School of Medicine employed on a strict full-time basis; all earnings from clinical activities are collected and pooled in the Faculty Practice Fund (FPF), established by the state govermment in 1959. Use of the monies in the Faculty Practice Fund is restricted to faculty compensation.

The following table presents statistics pertinent to this Institution.

TABLE 6

Statistical Data - 1967-76

	1967/68	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Student*	340	400	480	520	520
House Staff*	380	340	440	560	620
Full-time clinical faculty*	240	220	320	320	440
Full-time clinical faculty at Associate Prof. and above*	--	--	100	120	180
Total clinical volunteer faculty*	--	--	1420	1260	1460
Total regular operating revenues**	--	8,239	$10,025	$13,599	$15,906
Medical practice plan revenues**	$1,974	$ 2,576	$ 2,664	$ 3,492	$ 5,325
Sponsored research expenditures**	$6,105	$ 9,940	$ 9,237	$10,519	$12,031
Ratio Full-time clinical faculty to volunteers	--	--	.23	.26	.31
% of Full-time clinical faculty at rank of Associate Prof. and above	--	--	33.02	38.08	40.72
% Medical practice plan revenues to total operating revenue	--	31.20	26.57	25.67	33.48

*Rounded to nearest twentieth
**Dollar figures rounded to nearest thousand

B. The Plan - General Description and History

The policy of the state, historically, has been to peg public support of medical school expenditures only to that portion of the school activities that relate directly to instruction.

A law, passed in 1959, created the Faculty Practice Fund as a vehicle for charging, collecting and disbursing physician fees to be generated by the faculty members of the Medical School. Until then, faculty physicians were not allowed to charge for services rendered in the Medical Center facilities. This law made available a new source of funds which allows the school to augment clinical and non-clinical faculty compensation to competitive levels.

The law provides that, with few specific exceptions, all income derived from the professional activities of the faculty be assigned to the Faculty Practice Fund, and be used solely for compensation of faculty members of the School of Medicine.

In 1972, because of dissatisfaction with the performance of the plan during the previous years, (alleged misuse of funds, levelling off of income, faculty apathy), the Faculty Practice Fund's Organization and management structure were reshaped to provide for payment of incentive bonuses. Other minor organizational changes occurred in 1974.

1. Objectives

The plan postulates that the normal activities of the clinical faculty in the university hospital can generate large amounts of income from patients and that the growth of the Institution depends on the surplus generated by these activities.

The purpose of the plan is to provide the means for recruiting and supporting a faculty of high quality.

While the plan rests on the premise that all clinically qualified faculty members should take part in patient care, it should not create an environment to interfere with his essential academic functions and interests.

2. Organization

Governance of the Faculty Practice Fund is in accordance with the laws of the State, the governing policies of the University Board of Regents, and the by-laws of the School of Medicine.

The Dean of the School of Medicine is the administrator of the Faculty Practice Fund monies, subject to the approval of the Chancellor of the Meeical Center, the President of the University, and the Board of Regents.

The Faculty Practice Fund Committee, a standing committee of the School of Medicine, advises the Dean, the Executive Faculty and the administrators of the Medical Center on matters pertaining to the Faculty Practice Fund. The Faculty Practice Fund Committee is comprised of one member from each of the clinical departments (elected by each department's faculty) and four members representing all the basic science departments (elected by the entire basic science faculty); members serve for three years.

The business affairs of the Faculty Practice Fund are directed and coordinated by a full-time Manager, who supervises a staff of administrative personnel that function in support of the Fund. Activities include patient appointments and admissions, billing and collection of fees, processing of third party reimbursmment forms, etc. The manager serves as principal staff to the Faculty Practice Fund Committee and prepares periodic analyses and reports related to Fund activities and performance.

3. Plan Features

All members of the faculty with clinical competence in patient care are expected to accept responsibility for participating in such care. The responsibility for supervising the activity of faculty members rests with the department chairperson. Members of the Faculty Practice Fund Committee are expected to keep their departmental faculties informed of all pertinent aspects of the Faculty Practice Fund. All full-time

faculty members, as a condition of employment, are required to sign a contract by which they agree to abide by the regulations governing the Faculty Practice Fund. The provisions and restrictions of the Faculty Practice Fund are outlined in the contract form.

Overall jurisdiction over the disposition of the income derived from the Faculty Practice Fund rests with the State Legislature. The State each year takes a portion of the monies generated by the Fund to supplement the appropriations from State general revenues that support Medical School faculty salaries to levels and in numbers sufficient to meet the state's obligation towards medical instruction. The Faculty Practice Fund amount taken over by the state each year has increased from $877,000 in 1972 to $1,370,000 in 1977.

The balance of the Fund revenues is made available to the Medical School and it is used to: augment clinical and basic science faculty guaranteed base salaries and fringe benefits over and above the levels funded by the state; provide an incentive distribution to the departments that generate the income to be disbursed as additional compensation to their full-time faculty. The amount available for incentive distribution each year is determined by the Dean in consultation with the Faculty Practice Fund Committee, and depends on factors that take into account the accrued balance in the Faculty Practice Fund, cash collections, cash deficits, fiscal year expenditures and income budgets. Each department is allowed to adopt its own formula for equitably distributing this incentive to its faculty.

Under the school's system, therefore, guaranteed base salaries, for individual faculty members are derived from state appropriations, Faculty Practice Fund, capitation grants, research grants and other sources. Base salaries are determined by the Dean in consultation with the departments. The incentive bonus is not considered in the salary determinations. Each year the Dean, in consultation with the Faculty Practice Fund Committee establishes the maximum permissible difference between the lowest and the

highest compensation that can be paid to individual faculty members of equal rank. A ceiling is established on the compensation allowable for each rank. The limitations apply to professional income from all sources, including incentive bonuses.

4. Operational Aspects

As the plan operates, the Dean is essentially in control of the disposition of the income from the Fund. The Faculty Practice Fund Committee, chaired by the Dean, meets twice each month. There seems to be a feeling among the faculty that the Committee has little input on the decisions that are made concerning the fund. This is attributed by some to faculty apathy, by others to the fact that the Committee spends much of its time discussing administrative details and reviewing complex financial reports that the uninitiated find difficult to comprehend.

The administrative support of the Faculty Practice Fund involves three distinct units that function under the direction of the Faculty Practice Fund Manager. These are:

- The Private Patients Unit is responsible for the pre-registration of private patients, scheduling, and preparation of forms for admissions and assisting the physicians and the nursing units in coordinating outpatient appointment.

- The Administrative Support Unit is the core of the physicians fee charging and documentation system. It monitors patient medical records for proper documentation to prevent claim denials, or delays in the payment of these claims. It monitors the services of the medical staff to determine that recoverable professional fees are assessed, unless indicated otherwise by the physician. It prepares and processes charges for professional services rendered. It carries out administrative and procedural details

related to the total process of record keeping and recovering of physician's fees.

The Physicians' Insurance Billing Unit is primarily responsible for the completion and final audit for all physician insurance claims going to Blue Shield, commercial insurance companies, Medicare and Medicaid. Approximately 75 percent of the plan's collections for physicians' fees result from insurance claims. Because insurance billings are only approximately 34 percent complete when printed by the computer, this unit manually completes the bills, obtaining the necessary information from various source documents. The Unit also produces manual insurance bills for claims that cannot be processed through the computer system.

The Faculty Practice Fund accounting and collecting process is based on a computerized accounting and billing system which functions through the University Medical Center's Computer Service Department. Billing for some psychiatric services is done directly by the physician. The administrative and clerical staff in support of the plan numbers about 26 people. In addition, approximately 30 people provide clinical and technical support.

5. Benefits That Have Accrued from the Plan

The plan has allowed the school to build a quality faculty by providing more competitve salaries. This has also generated programs which the school could not have otherwise supported. The plan has opened a new source of revenue previously untapped.

The plan makes it possible for the school to distribute revenues in ways that do not discriminate between service oriented faculty and faculty whose functions are more prevalent in the instruction and research areas. This ensures that scholarly activities are not negatively affected.

The administrative features of the plan help generate procedures that tend to improve collections of fees and foster better record-keeping and documentation. Indirectly, the implementation of procedures stemming from the plan has helped improve staffing of ambulatory services resulting in quicker service to walk-in patients. The record-keeping and billing features of the plan document the extent of the financial benefits accruing to the State from the free care provided to indigents in the University Medical Center facilities. The statutory provisions which establish the conditions for the admission of full-time faculty physicians' patients ensure the availability of a larger pool and mix of patients to be used for teaching.

6. Finances

Revenues to the Faculty Practice Fund derive from:

a. All fees from patients, clinics and institutions for professional services, irrespective of where performed. Faculty members establish their own fees (the Faculty Practice Fund Committee provides a recommended fee schedule) and can determine when they wish the fee waived or discounted.

b. Fees for professional interpretation of laboratory results.

c. The professional component of the laboratory fees from laboratories serving routine hospital functions in the University Hospitals and clinics.

d. Consultation fees for services to commercial companies.

e. Honoraria earned in programs officially sponsored by the medical school.

f. Expert witness fees for medical-legal work.

g. Honoraria for visiting lectureships of

significant duration, involving one or more months, while on University leave with pay.

Expenditures from the Faculty Practice Fund consist of:

a. Contributions towards faculty salaries and fringe benefits.

b. Administrative (personnel and other) and general expenses of the Faculty Practice Fund (Health Care Support).

c. That portion of the University's malpractice premium that is directly associated with the Fund's clinical faculty members.

d. Departmental incentive disbursements.

The expenditures listed under item b, Health Care Support, are charged to the cost of operating the laboratories in the University Hospitals. However, these expenditures ultimately are borne by the Faculty Practice Fund because the amount of professional fees which the Fund earns from laboratory services is the difference between the reasonable amount that can be billed to the patient for a procedure and the total cost to the hospital for that procedure. For 1976-77, Health Care Support expenditures were estimated at $900,000.

The net revenues to the Faculty Practice Fund exclude uncollectible accounts, indigent care write-off, adjustments in third party reimbursements and policy waivers and discounts. Gross billings include all of the above, and are based on the value of all documented physician services to patients regardless of the patient's ability to pay and regardless of whether the patient is actually billed for these services.

Gross billings and net fund revenues have increased steadily over the years. For 1976-77 the projected net revenues amount to about seven million dollars, from gross billings of approximately twelve million dollars which include

indigent care write-offs. For fiscal 975-76, the net revenues were about 5.5 million dollars from gross billings of about 10 million dollars.

The propostion of total faculty compensation supported by the Faculty Practice Fund has risen from 26.6 percent in fiscal 1970 to 38.7 percent in fiscal 1977. The proportion of compensation derived from state general revenues has remained more or less constant, and the increase in Faculty Practice fund support has goen towards program improvements and as a sbustitute for decreased federal support.

The Faculty Practice Fund has been operating on a cash deficit basis because disbursements have been made on the basis of actual billings, and not on collections during a given fiscal year. The cash deficits, covered by the amount of receivables, have been advanced bu the University treasury. There is an effort to put the Fund on a balanced cash basis bu shortening the process leading to patient billing, by instituting a more aggressive policy in the collection of fees, and by curtailing expenditures.

7. The Departmental Incentive Plan

A portion of the net physicians fees generated by the members of each Department is returned to that department to be equitably distributed to the departmental faculty. The amount available for this departmental incentive distribution is determined each year by the Dean in consultation with the Faculty Practice Fund Committee. This amount varies each year, since it is dependent upon the income generated by the fund as well as upon other factors such as medical school funding levels from all sources, the total commitment of the school towards faculty base salaries and fringe benefits and cash collections. During the past fiscal year the amount of the incentive was half as much as in the previous year in spite of a sharp increase in faculty generated fees, because of a decrease in federal funding. Expenditures for these salaries, including new positions, were paid from money earned by the Faculty Practice Fund, rather than curtailing expenditures.

The faculty of each department determines how the department's allotment should be apportioned. Guidelines for these distributions, issued by the Faculty Practice Fund Committee include:

- The total compensation to each faculty member, from all sources, must not result in differences in individual compensation levels exceeding the maximum allowed by the school for that year.

- Items that may be considered "compensation" in dispersing incentive income include: salary, reimbursements for faculty travel, society dues, personal books and journals, and parking fees.

- The formula for the distribution of the incentive to the departmental faculty is determined by a departmental committee of at least two members or 10 percent of the departmental faculty whichever is greater, and must be approved by secret ballot by two thirds of the department's faculty members holding Faculty Practice Fund contracts.

The amount of the incentive bonus for the entire institution for 1976-77 was approximately $200,000. The Faculty Practice Fund Committee recommended that for 1976-77 this amount be distributed to the departments in accordance with the following formula:

- 4.4% of the net revenues generated by the department's faculty from professional fees.

- 4.4% of the income from payments for departmental faculty consultations to commercial companies.

- 4.4% of the net income from laboratory services which can be identified with the department's individual faculty member's effort.

- 1% of the net income of the professional component of laboratory fees

from those laboratories serving hospital functions, attributed to the department's faculty effort.

8. Attitudes and Comments of the Persons Interviewed

The visiting team interviewed a number of individuals that were chosen by the school as representing a cross-section of interests and perspectives impacting on the plan. Included were the Dean of the Medical School, the Manager of the Faculty Practice Fund, the current and a former secretary of the Faculty Practice Fund Committee, the Medical Center's Vice President for Administration, the Associate Dean for Clinical Affairs, three department chairmen, six faculty members from various clinical departments.

The cooperation on the part of the visited institution and on the part of all individuals that were interviewed was outstanding. No effort was spared to make the information available. Questions were answered with utmost frankness by everyone.

Those involved in the managerial and administrative aspects of the plan generally feel that the plan works and that it is the best that can be implemented for the present. They would like to see and are working towards improvements such as: liberalization of the allowed use of departmental incentives, recovery of indigent write-offs on the basis of ability to pay, elimination of the cash deficit, shorter intervals between services rendered and billing, better documentation of services, and changes in the statute to protect Faculty Practice Fund revenues from possible state encroachment.

The administrators would like to see more awareness among the faculty of the plan's function and features. There is a feeling among the administrators that many faculty do not understand the plan and do not have an interest in how it functions, and that their perception of the plan's performance is based exclusively on the amount of the incentive bonus.

The faculty members, including some of the

department chairmen, expressed varying opinions. Most approved of the plan feature that allows support of basic science faculty salaries. (For 1976-77, such support used about 16 percent of the Faculty Practice Fund revenues). There were differences of opinion regarding the incentive, with the high earners unhappy with the system. Those in specialties that do not have potential for high income more readily accept the status-quo. Some noted in this respect that the incentive plan was instituted with the approval of the faculty and that the vote in favor of the present system was 3 to 1.

The strongest, most prevalent criticism among the persons interviewed concerned the decline in the 1977 incentive in the face of the positive response by the faculty to pressures by the school administration for increased efforts to augment Faculty Practice Fund revenues. Most felt that the decrease in federal funds should have been offset by the curtailment of new hiring rather than substituting Faculty Practice Fund revenues. They particularly resented the absence of input by the Faculty that led to the decision.

Most of the persons interviewed voiced acceptance of the fact that academicians earn less than their colleagues in private practice, but they felt that if they wished to give up the enjoyment of academic life they could earn comparable incomes outside the institution.

There was disagreement over whether the Faculty Practice Fund has a positive or negative impact on faculty recruiting. Several people noted reasons other than levels of earnings influenced their decision to join the institution.

Some individuals voiced dissatisfaction with the performance in certain administrative and managerial support areas of the Faculty Practice Fund. These comments were reactions to specific issues and did not convey the feeling that there is a general problem in this area.

9. Team Observations

An observation common during all interviews

was a lack of passion and high feelings for and against specific issues, and that, in general, they appeared either comfortable or willing to live with the plan.

In spite of the disappointment and disagreement with the decisions leading to the lower incentive bonus this year, and the desire for more participation in distributing income, there was no groundswell for developing a new system.

There seems to be an awareness of the potential for the State Legislature to divert fund revenues to further offset State appropriations. The faculty is depending on the Dean and on the Chancellor to prevent that from happening.

10. Conclusions

This plan appears to be a reasonable compromise between the policy of the State and the needs of the Institution and of the faculty. The administrative aspects are reasonably well managed and are constantly under review for possible improvements. Substantive changes would require modification of state laws and institutional policies. Based on the observations, it does not seem likely that these changes will occur in the near future.

Operationally, the plan could benefit from a revamping of the governing committee structure. The Faculty Practice Fund Committee is large and unwieldly; its charge is too vague; it lacks continuity, by the time members learn the system, they are replaced by new ones. The Committee meets too often, deals inadequately with policy matters as it becomes bogged down with needlessly detailed financial reports.

The plan could be better understood by the faculty if all of its features and provisions, statutory as well as administrative, were written in a single document. At present, the incentive features of the plan are vaguely enunciated and are apt to be misunderstood.

The possibility exists that the incentive plan could be structured to produce higher revenues.

Currently there is little motivation to generate interest of the faculty to render patient billing and to provide adequate documentation to preclude delays or prevent billing.

More interest could be aroused if flexibility were permitted in the use of incentive allocations.

Regardless of these weaknesses, however, the plan has been and continues to be a major instrument in the maintenance of quality education at the Institution.

Case Study #5

A. Institutional Characteristics Relevant to the Practice Plan

This midwestern school was recently created by the State Legislature following completion of a four-year feasibility study by a local citizens' group.

The first medical school class was relatively small, but the current entering class is now 120, with an eventual planned enrollment of 150. The School has a 35-month curriculum, but consideration is being given to extending this to four years. Original operations were established in a local hospital. Since then, a new campus was planned and is now under construction. Facilities completed are a health science building and a building housing the library and administrative offices. A new 295 bed teaching hospital is scheduled for completion within the next two years. This construction program represents a capital investment of $100,000,000 provided by the State, the Federal Government, and private donations, with the largest funding being provided by the State.

This is a free-standing health science campus which is governed by a Board of Trustees appointed by the Governor. The Center is headed by a President, assisted by an executive administrative staff consisting of a Vice-President for Academic Affairs and Dean of the College of Medicine, Vice-President for Management Services, Vice-President for Finance and Director of Hospital Management. This group

meeting weekly, determines the administrative policy of the Center.

In addition to the regular teaching and service programs of the College of Medicine, there is a doctoral program in the biomedical sciences, a School of Health-Related Professions, a Consortium Program for Nursing Education and a Continuing Medical Education Program. Planning is under way to develop a graduate-level dental program and a masters-level program in nursing.

Clinical teaching and the private practice of medicine are centered in an old hospital of less than 200 beds. It is leased by the Center. Three prime affiliated private hospitals contain 1,644 beds; associate affiliations with the local Mental Health Center and another private hospital are also used. In addition, 47,000 out-patients and 17,000 emergency room patients are available for teaching in the University's Teaching Hospital.

The following table presents variables over time that are pertinent to this case study.

TABLE 7
Statistical Data - 1967-76

	1967/68	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Students*	-	40	120	160	260
House Staff*	-	-	100	140	180
Full-time clinical faculty*	-	20	40	60	80
Full-time clinical faculty at Associate Prof. and above*	-	-	20	40	40
Total clinical volunteer faculty*	-	-	220	300	340
Total regular operating revenues**	$948	-	$5,320	$8,868	$11,827
Medical practice plan revenues***	-	-	354	$ 40	$ 572
Sponsored research expenditures**	-	-	$ 690	$ 679	$ 1,377
Ratio of full-time clinical faculty to volunteers	-	-	.18	.2	.24
% of full-time clinical faculty at rank of Associate Prof. and above	-	-	50%	67%	50%
% of Medical practice plan revenues to total operating revenue	-	-	6.7	0.5	4.8%

*Rounded to nearest twenty
**Rounded to the nearest thousand
***Represents school expenses funded by the plan

B. The Plan - A General Description and History

The private practice plan was formulated in 1973 at the initiative of the faculty. The major objective of the plan was the generation of additional financial resources to permit retention and recruitment of faculty and to permit the Institution to reduce its commitment to the base salary support of faculty. The institution's professional practice plan is classified as Type 'A' under the AAMC's typology.

The affairs of the professional practice plan, including the development of and revision to the by-laws, policy interpretation, methods of income distribution, control of billing and collection procedures, and release of financial information are determined solely by the faculty. The Dean of the College is an ex-officio member of the practice plan and serves as liaison between the President and executive administrative staff of the Center. The Dean, however, has the opportunity to negotiate faculty members' base salary and supplemental income.

It was stated by one of the prime developers of the plan that it is realized that the plan is autocratic and completely separate from the College and the Health Science Center and was designed to avoid the pitfalls of plans at other centers. The plan is incorporated as a for-profit corporation, and although so far no taxes have been paid, it is anticipated that a tax liability will be incurred this coming year. The Corporation has a current accumulated deficit of approximately $500,000. The charter members give up control over the funds generated. They also wanted individual autonomy for administrative matters.

1. Organization

The control of the practice plan is vested in shareholders consisting of the clinical department chairmen. The shareholders elect a separate Board of Directors with staggered two-year terms. The Board consists of the department chairmen, one elected physician faculty member from each department, the Dean of the College of Medicine (ex-officio), and others as may be selected by the shareholders. The Board of Directors elects the corporation officers and an Executive Committee which meets every two weeks. Shareholders have the option of removing any director with or

without cause at any time.

Day-to-day operations are handled by a Business Director employed by the Corporation. Policy matters are reviewed by the Executive Committee of the Board. The Business Director has a staff of 18 full-time equivalent employees.

2. Plan Features

A centralized billing system is operated under the direction of the Plan's Business Director. Revenues of $3.2 million were generated during the last full year of operation (1976). Current unbilled accounts are approximately $2 million. To improve timeliness of billings and collections a new dedicated computer has been ordered and is expected to be operational shortly. A decision on installation of terminals in the departments has not yet been determined.

Operational reports are generated at the special request of the Plan's Executive Committee. The Treasurer's report contains little detail. No special reports are generated for the Dean or administrative staff of the Center. Most of the physicians interviewed indicated they routinely follow the status of their own accounts.

If a full-time faculty member does not join the plan he must relinquish all earnings from private practice to the school, and he is not entitled to any supplement or benefits from the school or the plan. Membership is optional for part-time physicians. Currently there are approximately 90 active members of the Plan. Employment agreements are maintained. Practice is permitted in the Center's Hospital and at affiliated hospitals. Patients at these facilities include in-patients, general out-patients, as well as those seen in the clinics and emergency rooms. Clinical departments have the option to operate their respective clinics at the Center's Hospital to improve the setting for patient care. Patient fees are the prerogative of the individual physician. One billing is rendered to the patient and, with the exception of ancillary charges, includes the use of hospital facilities, which are paid by the Plan.

Revenues collected by the Plan are credited to the individual physician and are limited to clinical care services only.

3. Operational Aspects

Faculty compensation is composed of a base salary, base supplement and an incentive supplement.

Institution Base Salary Schedule

Rank	Min.	Max.
Professor & Chairman	$28,000	$45,000
Professor	26,000	40,000
Associate Professor	24,000	37,000
Assistant Professor	16,000	33,000
Instructor	8,000	25,000

Base supplement is negotiated by the department chairman with the individual, subject to the approval of the Dean and the Plan's Finance Committee. The maximum supplement cannot exceed 75% of the base salary and is paid only if sufficient actual collections are made on behalf of the individual clinician.

In addition to salary compensation, pensions equal to 10% of the salary paid are funded by the plan and 33% of gross income is charged by the plan for overhead.

Currently, money from the overhead charge is used for the following purposes:

a. Costs of operating the Business Office

b. Medical liability insurance

c. Profit-Sharing Plan (the percentage is determined at the end of the year)

d. Employer's contribution to:

(1) Social Security

(2) Workmen's Compensation (.57% of remuneration)

(3) State Unemployment Insurance ($80 per individual)

e. Dues ($310 per individual)

f. Employees Beneficiary Association ($150 or up to 2% of Social Security base)

g. Faculty Development Fund (administered by the Dean equal to 10%)

h. Shared out-patient clinic expenses with hospital

i. Corporate faculty development fund for new faculty ($150,000 for a faculty member who does not earn sufficiently to cover his costs to the association

j. The Plan's Trust Fund equal to 6% of the overhead charge

k. Any balance remaining after payment of the faculty supplements and pension costs and the 33% overhead charges reverts to a departmental account.

The following is an example of an earnings distribution: In this example, the individual:

a. Is being paid a $10,000 salary from the plan.

b. Is eligible for the pension plan. (Eligible = one who has worked eleven months of the calendar year).

	$10,000.00	Salary
	1,000.00	Pension
67%	$11,000.00	Guaranteed Remuneration to Employee
33%	5,417.50	Overhead
100%	$16,417.50	TOTAL COST

Thus, of the individual's total cost to the corporation, 67% or $11,000.00 is paid to him in the form of salary and fringes; 33%, or $5,417.50 is charged to him by the Corporation as a cost of doing business.

If additional compensation is earned, it is distributed as follows:

a First Incentive = First $10,000 above break even point

$3,300 to the Plan for overhead
$6,700 to be divided as follows:

(1) $6,700 x 80% to Cash and Pension ($5,360)
$4,872.73 Cash
$ 487.27 Pension

(2) $6,700 x 20% to Department and Chairman ($1,34)
$1,116.65 Department
$ 223.35 Chairman

b Second Incentive - Second $10,000 above break even point
$3,300 to the Plan for overhead
$6,700 to be divided as follows:

(1) $6,700 x 70% to Cash and Pension ($4,690)
$4,263.64 Cash
$ 426.36 to Pension

(2) $6,700 x 30% to Department and Chairman ($2,010)
$1,675 to Department
$ 335 to Chairman

c Third (on) Incentive(s) - 3rd $10,000 (on) above break even point.

(1) $6,700 x 60% to Cash and Pension ($4,020)
$3,654.55 to Cash
$ 365.45 to Pension

(2) $6,700 x 40% to Department and Chairman ($2,680)
$2,233.34 to Department
$ 446.66 to Chairman

C. The Site Visit

During the two-day site visit interviews were conducted with eighteen faculty and administrators: These included: the Vice-President for Academic Affairs and Dean of the College of Medicine, Associate Dean for Clinical Affairs, Chairman of the Board of the Practice Plan, Business Director of the Plan, Health Center's Vice-President for Manatement Services and Treasurer, President for Management Services and Treasurer, President of the Plan, two Associate Professors in a joint meeting, Vice President of the Plan and Chairman of the Plan's Finance Committee, eight members of the Plan's Executive and Finance Committee in a joint meeting, and the Director of the Hospital.

Some specific comments obtained from those interviewed were:

1. "The plan should improve the timeliness of billings and collections."

2. "Better and more detailed reporting should be made to members."

3. "The overhead is too high."

4. "The current administration seems responsive."

5. "The plan is important in helping hospital occupancy and improving patient care."

6. "The plan has permitted the College to reduce base salary costs."

7. "There is no written information for the plan's participants."

8. "The plan needs corporate reponsibility to develop unmet institutional needs."

9. "Physician earnings are taxed for departmental funds rather than being distributed as additional salary."

10. "The plan is autocratically controlled by the Chairman."

11. "Memberships on the Board were expanded and the meetings are open for participation, but no one comes to these meetings."

12. "The larger departments should have more representatives on the Board than the smaller departments."

13. "The funds should be allocated to specialty sections within the department."

14. "The plan was formed to avoid pitfalls of practice plans at other health centers."

15. "There is no way to police physicians on earnings that they might receive directly."

16. "High earning departments should not subsidize departments with less earnings."

17. "Low earning departments should receive more subsidy from high earning departments."

18. "Producer physicians seem satisfied with the practice plan. Non-producers seem to gripe."

D. Conclusions

This is a relatively young plan at a young institution. Although this fact alone has caused "growing pains" with operational procedures and misunderstandings among participants, it has been of great benefit in helping the College to develop its objectives. Base salary costs have been reduced, and the financial incentive has enabled recruitment and retention of physicians. Distribution of income to the Dean and to departmental accounts has permitted enrichment and accelerated developmemt of the school's programs.

Past billing, collection and reporting have been inadequate, but it appears that the deficiencies have been recognized and are being remedied.

The plan is unusual in its complete autonomy from the school's administration. Complete control rests with the clinical chairmen. This fact apparently has not been of concern to the Dean or administrative staff probably because funds are currently being channeled in a way that has helped solve many pressing needs in addition to faculty compensation.

Case Study #6

A. Institutional Characteristics Relevant to the Practice Plan

This Northeastern Institution located in an urban setting has been a publicly supported free-standing medical center for a number of years after having existed as a medical college of a private university. This institutions practice plan is classified as Type B under the AAMC's classification system.

Since its public ownership, this Institution has developed from the sole program of granting the M.D. degree in the College of Medicine with an entering class of 52, (and only one paid clinical department) to a fully developed Center. The College of Medicine has increased the size of its entering class to 120, and with the completion of additional basic science facilities will accept an entering class of 140 this Fall and a class of 150 a year later. A new clinical campus is being developed and will become operational in two years at another urban community some 80 miles away. The new clinical campus, offering clinical teaching for the third and fourth years of the medical curriculum, will eventually have an enrolled class of 50. Thirty of these students will be transferred from the parent medical center, and the balance of the class will be filled with COTRANS'* students.

In addition to the College of Medicine, the Center conducts a graduate program in the Biomedical Sciences with an enrollment of approximately 60 and operates a School of Health Related Professions. The latter, with total enrollment of approximately 300, grants associate, baccalaureate and masters degrees in Respiratory Therapy, Physical Therapy, Medical Technology, X-Ray Technology, Nuclear Medicine, Cytotechnology, Extracorporeal Technology and in a program for Nurse Practitioners. An Associate degree program in Nursing was phased out last year; it is hoped that it will be replaced with a baccalaureate and masters' program in Nursing. Approximately 165 residents receive their training in the University Hospital, and an additional 175 are based at the Center's affiliated hospitals.

*Students that have received their early medical education in a foreign medical school and are accepted for reentry to a U.S. school through the Coordinated Transfer Application System.

The Center's teaching hospital has just under 160 beds, outpatient clinics with an annual volume of 90,000 visits, and an emergency service handling 35,000 visits.

The teaching hospital is a tertiary care facility serving a total population of approximately 2 million. Because of the relatively small size of the in-patient service, this facility has developed into a highly intensive care hospital. Each of the clinical departments has a base of operations at the University Hospital, except that OB-Gyn and Family Practice are housed in affliated hospitals. The Hospital maintains and staffs a private patient ambulatory facility. It is available for appointments with the clinical faculty, with a charge, based on scheduling, assessed to the physician.

In addition to the University Hospital, affiliations are maintained with a 500 bed private hospital which is physically connected, a nearby VA hospital of 500 beds and another community hospital of 400 beds. Minor affiliations are maintained with several other hospitals. Most of the private practice of medicine is done at the University Hospital with the balance at the prime affiliated hospitals.

The Medical Center is one of a number of State operated campuses coordinated by a Chancellor and centralized administrative staff responsible to a Board of Trustees. The local campus is headed by a President who reports to the Chancellor and Board. Other administrative officials are an Executive Vice-President and Dean of the College of Medicine, a Vice-President for Academic Affairs and a Vice-President for Hospital Affairs.

The following table presents statistics and key financial variables related to the school's medical practice plan.

TABLE 8
Statistical Data - 1967-76

	1967/68	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Students*	400	400	420	480	480
House Staff*	180	220	280	300	320
Full-time clinical faculty*	120	100	140	180	200
Full-time clinical faculty at Associate Prof. and above*	-	-	80	80	100
Total clinical volunteer faculty*	-	-	480	520	700
Total regular operating revenues**	$5,558	$10,221	$11,658	$14,168	$20,047
Medical practice plan revenues**	$ 149	$ 1,968	$ 3,327	$ 4,701	$ 7,358
Sponsored research expenditures**	$4,159	$ 2,308	$ 1,996	$ 1,924	$ 2,442
Ratio of full-time clinical faculty to volunteers	-	-	.3	.35	.29
% of full-time clinical faculty at rank of Associate Prof. and above	-	-	57%	44%	50%
% Medical practice plan revenues to total operating revenues	3%	19%	29%	33%	37%

*Rounded to nearest twenty
**Rounded to the nearest thousand

B. The Plan - General Description and History

Provisions for the practice of medicine by clinical faculty members were established as policy by the Board of Trustees of the institution in 1959. This policy permitted the formation of departmental practice groups; made membership optional; provided for the payment of expenses of practice; limited individual compensation to 50% of base salary; provided for the establishment of an overall Governing Board to monitor operating practices; prohibited retention of assets after the close of each year; provided for a central fund to receive all excess earnings; and restricted practice to University or affiliated institutions. Opportunities for practice, however, were very limited until the Center opened its own hospital and clinics in 1965.

Policies and procedures of the plan were refined by the Governing Board through the early 1970's at which time the State Legislature provided for collective bargaining which included the operation of clinical practice plans. The State-wide negotiators attempted to force implementation of central billing and to tighten controls on use of all generated income through the establishment of a non-profit Corporation. This was agreed to by the union in return for increasing the limit on retained earnings of up to 75% of base salary.

When the State was unable to obtain a favorable tax ruling from the Internal Revenue Service the Corporation was dropped and each of the States' medical centers was permitted to propose a set of by-laws for practice plan management for ratification by the State's Office of Employee Relations and the University's Board of Trustees. These by-laws have been finalized and ratified by the State and the Trustees.

The agreed upon by-laws for operation fundamentally continued the "status-quo" with the exception that they now require mandatory membership for all faculty clinicians whose compensation equals or exceeds 35% of the permissible base salary for their rank.

1. Organization

Each clinical department has its own clinical practice group with an independent accounting system handling charges, collections, and other business practices related to activities for that

department. There is an overall Governing Board made up of one elected representative from each group plus one representative from the basic science faculty, the President and the Dean.

2. Operational Aspects

Annually each department submits its anticipated budget for the coming year to the President, Dean, and Governing Board. Policies on types of expenditures are determined by the Governing Board using the criteria of tax deductability as determined by the Federal Internal Revenue Service. The following definitions have been established for expenditures which can be paid directly from the departmental practice funds.

a. Malpractice Insurance - Actual cost for coverage of all members in the group.

b. Legal Services - Actual cost of any legal fees for handling or advising relative to the group activities, including filing group tax returns.

c. Accounting Services - Costs of professional accountants for maintaining books and records of the group, including rendering advice on establishing adequate accounting procedures, providing bookkeeping services, billing and collecting, and preparing tax returns and other required accounting reports.

d. Employees - Costs of services and fringe benefits for those employees required to handle the business of conducting the practice and rendering patient care, including accountants, typists, stenographers and clerks for preparing and collection patient accounts, typing medical records, making appointments, etc. Employees rendering general services to the department or medical center should not be included in this category.

Employees required in this category should be employeed through an established account in the Research Foundation

and payment should be made to the Foundation by the respective Medical Service Group.

e. Fringe Benefits - Costs of providing retirement coverage for members of the Medical Service Group of up to 15% of the amount distributed to that group member.

Under current Internal Revenue regulations, income tax has to be paid by the individual on the amount contributed to a retirement program. The additional tax liability incurred on this amount may be paid to the individual in addition to his normal maximum distribution.

No other fringe benefit program costs can be funded as an expense of practice for those individuals receiving a State salary. Approved benefits are already provided from State sources. For an individual receiving total compensation from the medical service group, benefits equalling those provided by State may be funded from this source.

f. Car Allowance - An amount necessary to cover use of personal car in relation to rendering patient care as allowed by the Internal Revenue Service, but not to exceed $100 per month.

g. Use of Home for Office - No allowance

h. Professional Dues - Actual costs of membership in professional organizations. No allowance for membership in country clubs or other social groups.

i. Travel - Actual costs of travel for group members as allowed by Internal Revenue Service.

j. Gifts and Contributions - No allowance

k. Office Supplies and Expense - Including postage, stationary, telephone and telegraph charges and office equipment.

Items should be documented as directly related to rendering patient care.

l. Office Space - Charges made for use of facilities in State University Hospital.

m. Books and Periodicals - Costs of professional publications for departmental use.

Any other proposed expense should be submitted for budget review and should be approved by the President and the Governing Board of the Medical Service Groups and should be charged to departmental operations - not expense of practice.

Requests for distribution of practice income to the individual clinician are reviewed by the Dean and President for compliance with institutional salary schedules and overall equity. Departments are notified in writing of approved faculty compensation for the coming year.

A standardized reporting format has been developed for reporting fiscal operations of the department plan. Reports are submitted annually to the Medical Center Business Office where consolidated operating reports are prepared. The report includes a detailed listing of income distribution and fringe benefits paid for each clinician. These distributions are checked against the approved salary supplement for compliance with the institution's guidelines and policies.

An outside CPA firm is employed to examine the records of the department practice plan. In addition to the fiscal audit, bookkeeping and accounting practices are reviewed. Copies of the Audit report are furnished to the President, Dean, Vice-President for Administration and members of the Medical Practice Governing Board.

2. Finances

The Medical Center Business office bills each department plan for the assessment to the Dean's fund at the close of each year. The Business Office handled the record keeping and disbursements for the Dean. Gross income from this total activity in calendar year 1975 was $7,357,784.

This represented a large increase over prior year years; by 1976, the gross had increased to $8,650,000. Until recently, a two percent contribution of gross collections has gone to a Dean's Fund. By agreement, this has just been raised to five percent.

Funds collected by each discipline go into a discrete bank account. Certain practice expenses and allowable physician expenses in excess of base salary are paid directly from this account. Since some base salaries include a professional fee component, the monies needed to cover these commitments are also transferred to the Medical School. On an overall percentage basis, fee-for-service income has been distributed as follows:

a. To physicians as base salary, salary supplements or fringe benefits, about 44%.

b. For practice related expenses, about 19%.

c. For personnel and equipment related to patient care, and for departmental operations, about 18%. (All personnel employeed from private practice income are placed on the payroll of the Foundation, precluding the necessity of maintaining separate payroll and fringe benefit operations. Also, equipment and supplies are ordered by the Center's Foundation Office, which also handles invoices and maintains accounting records for the departments' restricted accounts).

d. For research support, about 9%.

The approximate 10% remaining goes either to the Dean's Fund (now 5%) or to Research and Development (R&D) funds in the Research Foundation established for each department.

All funds in departmental bank accounts are spent or transferred to the Research Foundation at the end of the year.

There is a ceiling on total earnings regardless of productivity. No individual is permitted to earn more than an additional 75% above the

base salary. In actuality, few achieve this level of earnings. Many voluntarily agree that income should be utilized for departmental improvement rather than take-home pay. In part, this somewhat unusual attitude is accounted for by a high level of State income tax in the higher brackets. The combination of Federal and State taxes may take up to 65% of upper levels of earnings.

C. The Site Visit

Interviews were conducted by a team of four with the following: President of the Medical Center, Chairman of the Practice Plan Governing Board, Dean of the College of Medicine, Acting Vice-President for Administration, Bursar (who coordinates reporting from individual departments, prepares consolidated reports and schedules audits by an outside CPA firm), seven department chairmen and six faculty members.

D. Team Observations

The overall plan has the enthusiastic support of both administration and faculty. There was no expressed desire to make any significant changes in the plan of operation.

Considering the number of separate operations, the institution has good total accounting and knows the disposition of all money. One of the secrets of the satisfaction level is that essentially all of the money (except the small Dean's Fund) is utilized within the department generating the income. Most believe that the systems are efficient in terms of picking up and billing for all work done.

Some doubts that all patients were being billed were expressed by a few in the final session. There is a strong incentive for each deaprtment chief to have an efficient system.

The administration and faculty have worked together to reduce interference by State bureaucracy to a minimum. They have resisted pressure to establish a central billing and collecting system and have used the Research Foundation as a haven for department R&D funds. Through this Foundation, these funds can be used without all of the usual State restrictions.

Primarily because those individuals earning in excess of base salary cannot participate in tax deferred retirement contributions, there has been some interest in individual or group incorporations. No specific action has been taken.

There is a firm conviction throughout the institution that a central billing system would erode the ability of the physician to have involvement with his patients and their accounts.

E. Conclusions

This school is an excellent example of the fact that there is no single organizational plan that will work well for all schools. They have achieved, with about 16 separate group organizations, what a number of schools with a totally centralized system have failed to achieve. Their success is probably due primarily to several factors:

1. These departmental plans have existed for a number of years, pre-dating most existing faculty, therefore, most faculty have been recruited with prior knowledge of the operating procedures.

2. The administration has allowed the excess income to be used by and for the department generating the income.

3. The administration has "protected" this income from bureaucratic encroachment by the State

4. The local tax situation has lessened faculty demands for more direct income.

Case Study #7

A. Institutional Characteristics Relevant to the Practice Plan

This institution, in the Northeast, is public and located in the ghetto area of a large metropolis, where together with the other components of the Medical Center - a dental school, a graduate college of biomedical sciences, a new teaching hospital (scheduled for completion in 1978), and a major State hospital affiliate- it functions as a prominent teaching institution.

The Institution's professional practice plan is classified as Type "B" under AAMC's typology.

In addition to the primary State hospital, which is being replaced by the newly constructed Center Hospital adjacent to the Medical School, a VA hospital and several other major and secondary affiliations, geographically dispersed provide teaching patients. The major State-owned hospital has over 540 beds which serve 14,500 annual admissions. The present indigent inpatient care load is 35-40%. Outpatient visits number over 80,000 yearly, and emergency room visits number 73,000. The primary teaching hospital under construction will be approximately the same size as the faculty it will replace. Thus, there will continue to be a need for the dispersed regional network of teaching hospitals to meet educational requirements.

The Medical School is responsible for just under 500 undergraduate medical students and some 440 house staff and it contributes as well to the M.S. and Ph.D. programs in the basic medical sciences and allied health sciences. To carry out these teaching commitments and the responsibility for a significant research and service load, nearly 340 full-time faculty are employed, 240 of whom are in the clinical departments. Of the latter group, about 160 are practitioners who would fall under the purview of the practice plan. Additionally, these departments utilize the services of a substantial number of volunteer faculty.

The programs of this institution are combined with those of other branch campuses in the State under a higher educational board headed by a Chancellor and governed by a ten member Board of Trustees appointed by the Governor. The organizational unit encompassing all of these programs is administered by a President; however, the Dean of the Medical School maintains academic responsibility for the programs of this campus.

The following table presents statistics and key financial variables related to the school's medical practice plan.

TABLE 9
Statistical Data - 1967-76

	1967/68	1969/70	1971/72	1973/74	1975/76
Undergraduate Medical Students*	300	320	400	460	500
House Staff*	-	280	280	380	440
Full-time clinical faculty*	80	80	180	160	240
Full-time clinical faculty at Associate Prof. and above*	-	-	60	60	120
Total volunteer faculty*	-	-	480	-	700
Total regular operating revenues**	-	$5,682	$8,155	$11,177	$12,360
Medical practice plan revenues**		not	available		1,000
Sponsored Research	$1,329	$ 846	$1,396	$ 2,353	$ 2,672
Ratio Full-time clinical faculty to volunteers	-	-	.37	-	.35
% of Full-time clinical faculty at Associate and level	-	-	37.9	44.2	48.3
% Medical practice plan revenues to regular operating revenue		not	available		8.1

*Rounded to nearest twenty
**Dollar figures rounded to nearest thousand

B. The Plan - General Description and History

The practice plan at this institution allows the individual clinical departments considerable flexibility in the administration of the funds generated by their faculty.

The present overall Plan evolved in 1971 from joint efforts of faculty and administration, but was revised by the Board of Trustees in July 1973. According to the Plan's by-laws, it has been recognized that the departments and divisions "have individual needs and requirements that cannot be accommodated by the establishment of a single 'monolithic' system...". Thus, each entity is permitted to act on its own in administering its funds as long at the respective distribution formula has been approved by the Trustees.

This freedom has extended to the areas of faculty billing and collecting. Because of the dispersed nature of in-patient clinical activities and the lack of a central locus for ambulatory patient care, private offices, including administrative functions, have been located apart from the institution's premises after receiving advance authorization from the Trustees.

The Chairman of the Board of Trustees actively participated in the Plan's evolution and he continues to advise on aspects of day-to-day administrative procedures. Significant turnover within the Medical Deanship has probably contributed to this unusual involvement.

Several specific rulings have recently been presented to the institution by the State Attorney General's Office relative to the Plan's administration. Following the President's request for the State's clarification of legal status and proper administrative procedures under the Plan, a formal opinion was rendered by the Assistant Attorney General in September 1976. In summary, this opinion stated that the Faculty Practice Plan activities are operationally under the Medical School, a State entity, and therefore are subject to statutes and regulations applicable generally to the School. This position and specific administrative procedures which will have to be put into effect to bring the plan's operation into compliance with the opinion have been the subject of a growing conflict between administration and practicing faculty. The specifc issues are discussed subsequently

in this case study.

1. Objectives

The Preamble to the written practice plan emphasizes the faculty's responsibility for providing high quality educational programs, prototypal health care and creative investigations in understanding and controlling disease. The Statement of Purpose for the plan stresses the provision of clinical skill throughout the State to all patients regardless of location of residence, economic status, or type of illness, under a system of high standards in a "dignified atmosphere."

2. Organization

The Faculty Practice Service (FPS) was created by, and is under the ultimate authority of, the Institution's Board of Trustees. Functionally, the College President has the delegated supervisory responsibility for the plan. Although the College is a State body and thus subject to State laws and administrative policies, until recently State jurisdiction over the Faculty Practice Service Plan had not been clearly established. At the moment, the extent of State regulation is still being challenged by the faculty.

The role of the Dean of the Medical School is not detailed in the written plan, although it is established that he has some responsibility for assuring that faculty participation in the plan does not conflict with academic programs or other obligations. He is involved with the annual faculty salary negotiation process, and he is a member of the Plan's Professional Board.

The activities and affairs of the Faculty Practice Service are directed by the Professional Board, composed of elected members from among those clinical faculty who participate in the plan. They are selected proprotionately from each clinical department based on one representative for fifteen voting participants or respective fractions. (voting participants are those who spend at least 50% of their time at the College Hospital or affiliates. The Chairman of the

Board is elected by its membership and is authorized to designate committees necessary to conduct the missions of the Faculty Practice Service. An Executive Committee is comprised of one elected member of each clinical department, the Executive Committee Chairman of the principal teaching hospital, and several other management and academic administrative officers of the institution who serve without vote. It is charged with responsibility for operating the Service. The day-to-day administrative duties as outlined by the Professional Board are carried out by a Business Manager with subordinate accounting and clerical staff.

A striking feature of this practice plan is the recognition that clinical departments and their divisional components have unique requirements which cannot be adequately met under a single "monolithic" system. Accordingly each entity acts on its own, subject to appropriate approvals by higher levels, to bill, collect and administer funds. A departmental Steering Committee is provided in each case to provide "necessary intra/departmental guidance."

3. Plan Features

As a condition of employment, most full- and part-time faculty licensed to practice in the State are required to be members of the Faculty Practice Service and to adhere to the Plan's provisions. A signed contract, renewable annually, attests in detail to this obligation. Further, this Institution has a negotiated faculty union contract which recognizes the compensation conditions set forth in the practice plan. As currently written, the plan does acknowledge that certain faculty members are under signed agreements with "other employers" that preclude their participation in the FPS. Such arrangements are being phased out.

The plan stipulates that all income derived by full-time plan members from patient service activities at the Medical School, its affiliates and at unaffiliated sites is to be deposited into the Faculty Practice Service account. (Note: There is no reference as to location of or con-

trol over this bank account, a point of growing controversy in the plan's operation). The plan recognizes the temporary state of inadequate centralized practice facilities. Wide dispersion of clinical practice locations has resulted in the decentralized collection processing described above.

Faculty compensation is the most significant use of plan revenue. There are two major compensation components: first is the minimum guaranteed salary, which is negotiated annually between the individual, the Department Chairman, and the Dean. This salary component has two parts: (1) an academic base which follows a State schedule of salary ranges by academic rank, and (2) a clinical salary element, part or all of which may derive from practice plan revenues according to varying departmental distribution formulae. Other funds, however, such as from Federal grants, may likewise support this element. Regardless of productivity under the plan, an individual's annual salary will not fall below the guaranteed minimum. Whenever practice plan funds are inadequate in a given department to support this compensation element for its faculty, the shortfall is prorated among the available plan accumulations of other departments, to be repaid in subsequent years when surpluses are available.

Second, an individual incentive is possible, assuming practice plan funds are available in a department after the department's faculty minimums are provided for. The departmental distribution formulae likewise govern the extent and manner of the incentive distribution. In no case may the maximum allowable total compensation (minimum guaranteed salary plus incentive payments) exceed twice the top step of the base salary schedule for the given rank.

The plan specifies that gross income to the Faculty Practice Service is initially reduced to support overhead; i.e. cost of billing and collecting, legal fees, medical support, and facility maintenance. The next lien against the plan's revenue is a progressive tax for the Dean's Fund. This is on the basis of departmental collections (net of overhead) at the following rate: 5% of

the first $150,000, 10% of the second $150,000, and 15% of the net above $300,000.

After overhead recovery and Dean's Fund obligations are met, the departmental allocation arrangements take effect in the distribution of plan revenue. These schemes, approved by the institution's Board of Trustees, vary considerably. The faculty of each department through their plan-provided Steering Committees have a voice in developing the distribution formulae. Each departmental plan includes a standard provision for covering the guaranteed minimum salary component and the cost of fringe benefits for all plan members in the department.

Each arrangement provides for an "overage" accumulation, to be distributed: 60% to the department, 30% to the Deans' Fund and 10% to an institutional reserve account.

The departmental variations appear primarily in the percentage of funds going into the departmental discretionary account and how the overage point is reached. One department, for example, follows a formula which allocates 15% to its departmental fund for the first $10,000 of income generated by the individual. Excess is split evenly between the earning individual and the departmental fund; only after the maximum allowable salary is met are additional earnings counted as overage. Another department allocates first 20% to overage; the excess between guaranteed minimum salary and maximum allowable salary is distributed between the earning individual and the department on a sliding scale which extends (for the first 25%) from 90% - individual: 10% - department to (for the fourth 25%) 25% - individual: 75% department.

4. Operational Aspects

Practice plan revenue does not appear as a very significant resource to this School. Approximately $1,000,000 was recorded for FY 1976. The collection rate against billings for a recent 9-month period was 74%. The smallness of the income figure reflects a very high indigent patient load at the School's primary teaching hospital, and the fact that the State has disallowed the collection of $1.2 million of Medicaid reimbursements by faculty practicing at that Hospital. (See subsequent discussion on p.118).

Operationally the department chairmen at the moment are in control of the disposition of the income generated. Great latitude has been granted to, and some latitude has been preempted by the clinical departments. Faculty who collect their fees directly do not currently turn over their collections, but accrue up to the amount they are due. Further, those who practice outside the School's facilities or affiliates deduct their own overhead (in lieu of the full plan-mandated overhead assessment). What constitutes a legitimate overhead plan-mandated deduction is not well defined; as a result overhead deductions of 60% or 70% of collections do occur.

This plan was found to function independently of the School. The billing and collections office is headed by a Business Manager, who together with his subordinate staff are employees of the plan, not State employees. The manual bookkeeping and financial reporting system is a result of an inability to gain State approval for automated systems.

Although the Dean serves as a non-voting member of the FPS Executive Committe/Professional Board, he has rarely attended the periodic meetings. Rather, an Associate Dean (not a clinician) represents the Dean on occasions, and in general functions as a liaison between the Dean and the President in the practice plan area.

C. The Site Visit

There was mixed feeling among the faculty in their

views about the present practice plan. Those who were very positive about the plan often were faculty with practices at the periphery of the School's "catchment" area". It is possible that they would favor the current arrangement because it is easy to work around the system. There was uneasiness, particularly among the more junior faculty, that the rules of the plan are inconsistently applied; the result is a "rumor mill" that churns continually. Some clinical chairmen were critical of the plan, because it provides an inducement to conduct remote-site practice, often unrelated to teaching. A plan, it was felt, should very definitely relate to the educational mission of the School. Similarly, the chairman of one clinical department, heavily committed to the care of indigent patients in the major teaching hospital, thought that the plan had not addressed the role of the Medical School in attracting faculty to "ghetto medicine." Service commitments to the inner-city area were not being met, he said.

As to "pocketbook" matters, most of the junior faculty interviewed accepted the premise that this plan was not designed to make the faculty practitioner rich nor should it be; its value lay in providing the departments and divisions with the funds for the necessary resources, including a competitive compensation scale to attract and retain a good faculty.

During the two-day site visit, hour-long interviews were conducted with faculty and administrators. They included: the President of the Center, the Dean and an Associate Dean of the Medical School, the Financial Vice-President of the Center, seven clinical department and division chairmen, five junior faculty, and three members of the business staff. Most of the clinical specialties were represented. The visiting team was warmly welcomed by the faculty and staff. There was little apparent withholding of personal views and concerns about the practice plan. The site visit team included an associate medical school Dean for patient services, a medical center administrative Vice-President, and one AAMC staff member.

D. Key Issues

A number of issues surfaced during discussions. Some of these issues relate to transitory administrative procedures while others are more seriously concerned with fundamental philosophy. Most remain unresolved.

1. Structure and General Administration

There is general feeling among the faculty, as determined by interview, that the basic principles and operating procedures of the present practice plan are satisfactory. A few felt that some of the language in the written by-laws needs refinement and amplification in portions and that such improvements could be easily accomplished. Top executives of the Institution and Board of Trustees, although generally satisfied with most of the fundamentals of the plan, have grown uneasy over differing interpretations surrounding administrative practices. The plan as now constituted is too general and has retained language which addressed a temporary state of affairs (in 1971) which is no longer valid. As a result, faculty have been permitted great latitude in their practice location, method of billing and collecting for their services defrayal of overhead costs of practice, and banking of funds collected.

The conspicuous lack of involvement of the Dean in policy and procedural questions was noted by several interviewees. For example, the Dean has rarely attended the monthly meetings of the FPS Committee. On the other hand, there is the strong but respected presence of the President and the current Chairman of the Board of Trustees in practice plan matters. Some questioned the propriety of the resulting "maldistribution" of authority for often petty-, day-to-day administrative details. According to one clinical chairman, the President should serve as "agent of the Trustees" in executing surveillance over the basic missions of the Institution, while the Dean should be responsible for deploying the necessary resources to insure program outcomes.

Many state regulations imposed on the Institution in general have been avoided by the units of the Faculty Practice Service. However, there have been inexpedient experiences with some State administrative requirements. These include a triple-bid system used on equipment purchases, severe limitations on travel, and a generally negative State attitude on acquiring automated systems. In spite of these frustrations, the

faculty are generally appreciative of the efforts of the FPS Business Manager and his staff.

2. Legal and Regulatory Issues

Because of the divergence of view concerning the business administration of the Faculty Practice Service, between the executive leadership and the clinical faculty, the President in the Spring of 1976 sought an opinion from the State Attorney General's office. The question was posed: "Can the Faculty Practice Plan itself, including accounting structure, books and rule applications, be outside...(institution) and hence, outside State jurisdiction?" The response by September was that as presently organized, the plan is a "creature" of and subject to the direct supervision and control of the Board of Trustees. Consequently, it is bound by the institution's rules and regulations and by "all State statutes and regulations generally applicable" to the institution. As a result, in "those instances where present practices or procedures deviate from applicable...regulations, the plans shall be amended to conform to the appropriate authorities." The effect on long tolerated operations was quickly recognized as profound. The following changes were identified as necessary to bring the plan into conformity with the Attorney General ruling:

a. All personnel - administrative, professional and clerical - working directly for the plan were to be employees of the institution (or State), not the plan, regardless of where located (faculty permitted private office practice had commonly employed staff independently of the institution). State compensation and benefit policies, employment duties and qualifications, and recruitment practices were to be the only authorized mode.

b. All of the financial records of the plan were to be kept in the same manner as those of the parent institution, and were to be subject to State audit at any time. (Records were inconsistent with those maintained by the School and had not been

audited.

c. Outside bank accounts were to be discontinued, the funds to be turned over to central institutional accounts. (Outside accounts had been commonly accepted).

d. Investment of funds earned under the plan was to be handled solely by the State's Department of the Treasury.

e. All purchases, contracts, and agreements, including facility leases, required by the plan were to be subject to State purchasing procedures. (There had been no standard purchasing contract practices).

When the State's ruling and its implications were understood by the practicing faculty, the reaction was traumatic and universal. A growing polarization occurred, with the faculty desirous of preserving their independence from State bureaucracy, and administration compelled to execute officially sanctioned policy. One key business administrator felt that there had been an over-reaction on the faculty's part, and that the State's administrative "red-tape" was not as harsh as imagined; all that was needed to work under the rules and regulations was advance planning by the faculty.

A rather prompt reaction by an increasingly dissident faculty to this set of events was the involvement of the Faculty Practice Service's outside counsel in the matter. (A firm had been under retainer by the FPS to advise on separate issues, but this was now a clear violation of the State rules, which stipulate that only the Attorney General's staff can provide legal opinion for a State entity). This outside firm countered the State's formal September ruling with an opinion "based on factual and legal analysis" that the FPS was not a "creature" of the institution and thus not subject to the State statutes and applicable rules. This brief suggested that a complaint be filed with the State Superior Court seeking legal affirmation. At the moment, the State Attorney General's office is reluctant to negotiate with an "illegal" counsel.

The Chairman of the plan's professional Board has become the major spokesman for the clinical faculty on this problem and in summary feels that the present climate is counter-productive to maintaining a quality faculty. He was joined by many others among the interviewees in predicting a "mass exodus" of faculty from the School should the full impact of the Attorney General's ruling be realized. The President and Board of Trustees are reported ready to risk that possibility.

One other possible "ripple effect" was suggested by a Deputy Attorney General newly assigned to the case. The faculty union contract now valid was premised on the 1973 practice plan. Should the plan change materially, it is probable that a new union agreement will have to be negotiated.

A major problem came to light from the interviews concerning the inclusion of certain third-party reimbursement revenue. The collection of Medicaid funds associated with the faculty's practice at the major State-owned hospital affiliate had initially been viewed as a conflict of interest, i.e., the faculty could not "double-bill" a system that was already providing much of their compensation as State employees expected to render indigent care. Several years of controversy over this issue finally led in October 1975 to an Attorney General's ruling that the faculty of the institution who were Medicaid providers could legitimately render claims under that program. The "thorny" issue, however, became retroactively of back payments by the State. One prominent department chairman indicated that this problem had abated with the school dropping its claim to retroactive payment.

Although annually each member of the Faculty Practice Service is obligated to sign an employment contract indicating the agreed upon compensation terms, it became clear during the interviews, several months after the due date for the contract, that only about 10% of those faculty entitled to a guaranteed minimum salary had executed their agreement. The reason seems to stem from the structure of the contract document, i.e. too standardized a form to adequately address the various clinical compensation supplement

possibilities.

Professional liability insurance has had considerable faculty and administration focus over several years. The major issue is whether or not those faculty who have unauthorized outside practices are covered by the institution's self-insurance reserve fund. The administration has made it clear that such individuals are not so protected. One Orthopedics faculty member, though legitimately covered by the School's policy, expressed strong reservations over whether the institution has adequate resources to protect a specialty group so subject to suit.

3. Practice Setting and Hospital Relationship

The situation of inadequate facilities to accommodate the clinical faculty and their practices has long existed at this school. The dependence upon a "centrifugal" network of hospital affiliations in the absence of a large institutional hospital has contributed to the faculty's establishing their practices at sites remote from the Medical School. Also contributing to this decentralization has been the recognition that many private patients are reluctant to receive care in deteriorated areas. The practice plan at this institution has been lenient in permitting practices to take place in outside quarters, provided authorization in advance is approved by the Board of Trustees through the plan's Professional Board.

The Central Administration has noted a conspicuous absence of advance approval for such off-site offices. The counter claim from the Faculty Practice Service's leadership is that permission requests had been made, but had not been acted upon by the administration.

There is some likelihood that the need for outside practice sites will diminish in the near future, as current interim administration facilities are vacated with movement to the new adjacent Hospital and Medical School structures. There do seem to be mixed views among the faculty and staff interviewed as to how soon and whether or not, in fact, such quarters will be made

available for private practice offices. These prospects, in addition to access to private and semi-private patient accommodations in the new Hospital expected to be complete in early 1978, suggest that the current issue over outside practices - legitimate or otherwise - will moderate. At least one clinical chairman, however, feels the new 513 bed facility will be inadequate, and that the allure of present accommodations to a suburban patient population hesitant to travel to an inner-city facility - no matter how new and attractive - will be factors to overcome.

4. Financial Considerations

The single issue arousing the sharpest exchange between clinical faculty and administration is the existence of faculty practice bank accounts outside the Medical School, and hence outside of control of the State. Though this arrangement was neither allowed nor prohibited by specific reference in the written practice plan, it had apparently been condoned by the administration for several years, as long as proper collection rules and reporting procedures were obeyed. As early as Spring 1973 the President had authorized the creation of the outside account(s) for funds generated only from patient care services provided at locations other than those under institutional control; income arising from services provided in school facilities was not to flow through those accounts. The State Attorney General's September 1976 opinion has ruled against the existence of any outside accounts. By April 1977 the Faculty Practice Service was instructed by the President to transfer all private bank account funds to a Medical School account. He promised that no monies would be withdrawn from the account without approval of the plan's Business Manager, and that all transactions of the account would be open to the Plan's business office for review. In response, a number of specific technical questions were raised by the Chairman of the FPS governing body, e.g. "Can FPS officers and business mangers be signatories on the proposed account?" "How would FPS audit the fund accounts?"

An underlying fear on the part of many faculty

and some administrators with respect to having practice plan income under the Medical School's set of accounts is that this resource will become conspicuous in its significance to the State. The consequences might be for State budget officials to regard this item as a legitimate State budget offset, thus reducing the State's net appropriation to the School. Current State budget instructions do provide, for the first time, for specifically identifying plan earnings; they had previously been sheltered as restricted funds.

Conspicuously absent from the current written practice plan is a description of the nature of financial reports which reflect periodically the status of plan revenue and obligations. Also missing is a definition of the type of records which need to be maintained to meet State audit standards. Until two years ago, State auditors had been unable to audit anything other than the "bottom line," finding little control in the files and no tracking system. In short, they found the fiscal records, according to one administrator, "in a shambles." Although aggregate fiscal data has greatly improved, there has not been a good reporting scheme for individuals which would allow auditors to carry out a thorough review at that level. Interviews with the Plan and the School business administrators did reveal a growing spirit of cooperation in sharing practice plan fiscal details, although these are mostly at aggregations above the individual, e.g. monthly reports of billings, collections and receivables by departments. One problem surfaced which affects the nature of fiscal records and audits; State accounting is on an accrual basis, while FPS records are on a cash system.

The presence of central billing and collecting received a generally positive endorsement from the faculty interviewed. One prominent clinical chairman for a high earning department expressed preference for a centralized function, which should tend to insure consistent and reasonable compliance and thus minimize rumors of violations. The absence of compliance with centralized billing and collecting may be attributed to the many faculty with off-site practices who take care of this function on their own. Should they be

forced to use the central service while maintaining their separate practices, sharp reaction would be expected.

One additional fiscal issue needs comment. The written practice plan is not explicit regarding a means for monitoring income earned by the faculty member outside of those amounts handled directly by the FPS business office. Nevertheless, the requirement that such individuals furnish to that office either a copy of IRS Form C, an accountant's statement or letter with specifics has become a routine requirement. There is suspicion among some administrators and faculty as well, that there is inconsistent enforcement of this monitoring method. To help allay this concern and the feeling that other practice plan rules were being violated, the administration in 1976 requested the State Auditor to review the plan's operation on site and if necessary to inspect individual's private income tax records.

E. Conclusions

It was readily apparent to each of the site visitors that clinical faculty and administration are set on a collision course should the present polarized views regarding State jurisdiction persist very much longer. Legal action appears very possible, the consequences of which, should the court rule on the side of the faculty, would have broad national repercussions. There does seem to be room for compromise in many areas. For example, plan generated funds could be sheltered in a separate entity, e.g. foundation. Although protected from the more onerous State regulations, sound administrative practices could be established by plan and School administrators, and an acceptable earnings monitoring system consistenly applied. A foundation, in fact, does now exist as a non-profit corporation organized under State laws for broad charitable, scientific, literary and educational purposes. The strong argument could be made to the State that although the plan might technically be a "creature" of the State since the faculty members are public employees, overly restrictive administrative regulations might tend to discourage the practitioners from carrying on that activity and following through with the necessary billing procedures. Moreover, financial support for the School from this source should be regarded

positively by State officials as a relief to tax-based appropriated funds.

One particularly troublesome matter is the decentralization of practice sites. It is likely to diminish once the new hospital and renovated practice facilities become operational. At that time central billing and collecting would be more practical to enforce. Thus the need for monitoring individual IRS tax statements may become moot.

The reported amount of funds generated by the practice plan is not impressive. Although the size of the full-time clinical faculty is not large and there is a heavy service responsibility for indigent patients, net income to the plan could very well be less than the potential. This too is likely to be remedied with the prospects of greater control in a more centralized patient care setting and with imposed central fee handling. In particular, the present laxity and inconsistency in determining a fair cost of practice overhead figure, closely monitored, is detrimental to the accumulation of funds.

This school, in summary, has a faculty dedicated in general to the Institution's objectives, not the least of which is the delivery of first rate care to an underprivlieged population. A well drawn practice plan consistently and competently administered and communicated can and should assist in that mission.

FOOTNOTES

1 Association of American Medical Colleges, Medical Practice Plans at U.S. Medical Schools, A Review of Current Characteristics and Trends (Vol. I). Washington, D.C., AAMC, 1977.

2 Ibid., p. 21 et.seq.

3 Ibid., p. 20

4 Ibid., pp. 42-43

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A P P E N D I C E S

Appendix A - Sample letter sent to medical school inviting participation in the study

Appendix B - Suggested Interview Schedule

Appendix C - Interview Guide

Appendix D - Sample letter sent to medical school requesting approval of initial case study

A P P E N D I X A

Sample Letter Sent to Medical School
Inviting Participation in the Study

association of american medical colleges

Date

Dear

I am following up recent telephone discussions with on the following topic. As you know, the Association of American Medical Colleges has been involved for several months in a comprehensive Study of Medical Practice Plans. The project's scope and objective has been a nationwide review of medical school practice arrangements, leading to descriptions of the structure and operations of some seventy plans found to exist in documented form. The effort is intended to result in broadened knowledge of the current state and trends concerning medical practice plans. Thus, medical schools developing a plan for the first time, or preparing to alter an existing plan, would have the outcome of this study as a ready reference work.

The first year's efforts on this two-year study have concluded, and an interim report will soon be released to the schools and other interested parties. This phase of the study focuses on the organizational and administrative details of the individual plans received, findings are summarized, and trends over two decades analyzed. Further, an annotated bibliography on the subject of practice plans was published. The interim report will also include a typology, under which the plans studied are classified. A set of income flow diagrams are also included and described.

The Association has begun the second phase of the Study of Medical Practice Plans. The primary thrust of the second year will be an in-depth review of six selected plans. This will be done onsite where it is hoped that a representative group of school administrators and faculty can be interviewed. The result will be a written

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case study which addresses more the "physiological" than the "anatomical" characteristics of the practice plan. Each school will have the final say on what is said, and how it is said. Further, they will be kept anonymous in the final published report. A number of issues will be addressed in the interviews, such as plan objectives from the perspective of various individuals affected by the plan, motivating forces bringing a new, or modified, plan into being, among other discussion items.

The six institutions to be studied will be representative of a broad spectrum of characteristics. It is our intent to review the plans in at least three state schools, as well as examine practice arrangements which are more formal, centrally structured, versus those less structured and decentralized at the departmental level or below. It is also our wish to include in the study both those plans which have undergone some recent major change, in order to review influencing forces, as well as the more stable plans.

The site visit will be conducted by a team of three or four individuals over two days. The visitors will include at least one AAMC staff professional; the balance of the team will be staff from other institutions. The latter will be either members of the project's Advisory Committee or consultants to that body and will include a dean or other clinical academician. It would be beneficial to the study to visit individually for an hour or so with the Dean of the medical school, its chief financial officer, the practice plan manager, hospital administrator(s) if involved with the plan, the current chairman of the plan's steering or advisory committee, and chairmen of active clinical departments such as surgery and medicine.

We very much appreciate your interest in this project and would like to include as a case study. Yours would be the first visit, and as such, will serve to pilot-test our case study methodology. As to timing, and assuming your willingness to be involved, would Wednesday, April 6, beginning at 9:00 a.m., and extending through April 7, be acceptable? We can look at other dates if need be.

Additional details, including names of the site visitors and topical areas to be covered during the interview, will be sent shortly.

Sincerely,

William C. Hilles
Associate Director
Division of Operational
Studies

A P P E N D I X B

Suggested Interview Schedule

Proposed Schedule - Day 1

Breakfast meeting with Dean	7:45 a.m. - 8:45 a.m.
Interview #1	8:45 a.m. - 9:45 a.m.
#2	9:45 a.m. - 10:45 a.m.
Interlude	10:45 a.m. - 11:00 a.m.
#3	11:00 a.m. - 12:00 p.m.
Team Summary Session (Taped) and Lunch	Noon - 1:30 p.m.
Interview #4	1:30 p.m. - 2:30 p.m.
#5	2:30 p.m. - 3:30 p.m.
Catch-up Period	3:30 p.m. - 4:00 p.m.
#6	4:00 p.m. - 5:00 p.m.
Team Summary Session (Taped)	5:00 p.m. - 5:30 p.m.

Proposed Schedule - Day 2

Interview #1	9:00 a.m. - 10:00 a.m.
#2	10:00 a.m. - 11:00 a.m.
Interlude	11:00 a.m. - 11:15 a.m.
#3	11:15 a.m. - 12:15 p.m.
Team Summary Session (Taped) and Lunch	12:15 p.m. - 1:45 p.m.
Interview #4	1:45 p.m. - 2:45 p.m.
#5	2:45 p.m. - 3:45 p.m.
Catch-up Period	3:45 p.m. - 4:15 p.m.
#6	4:15 p.m. - 5:15 p.m.
Team Summary Session (Taped)	5:15 p.m. - 5:45 p.m.

A P P E N D I X C

Interview Guide

MEDICAL PRACTICE PLANS

I. Organization

A. Legal Structure

1. Why was the current form chosen?

2. What are the advantages (disadvantages) of this type of association?

3. Have alterations to the basic structure occurred since conception of an institutional plan?

4. If yes, what changes have been made?

5. From which source(s) administration, faculty, state, etc., did pressure for change emanate?

6. How was change effected?

B. Administrative Structure

1. What is the network of authority and communication through which plan goals are transmitted?

2. How has this system abetted achievement of designated goals?

3. Where do breakdowns occur?

4. Who promulgates management policies?

5. What distinction is there between policy-making and management actions?

6. Who serves as the principal link between the source of governance and the professional medical staff (faculty)?

7. What is the scope of this person's responsibilities?

8. Who functions as administrator for non-medical plan activities?

9. How large is the supervisory and technical staff supporting the function of plan administration?

10. What group(s) assists plan administrator(s) in functions of planning and decision-making?

11. How is the plan affected when a major change occurs in the administrative structure of the medical school?

12. What are the special characteristics of this plan that seem to affect its management structure?

C. Membership

1. What variations in administrative policies and financial regulations exist for members?

2. How is a grandfather clause implemented?

3. What is the effect of plan membership on physicians' perception of their autonomy?

4. How are accommodations made to placate dissident members?

5. What factors preclude plan domination by an individual or sub-group (medical specialty)?

6. How does the community physician relate to the plan?

D. Practice Setting

1. To what extent can plan participants agree to provide patient services outside the purview of the plan?

2. How are teaching patients distinguished from private ones?

3. What obligation(s) do physicians have for acquiring facilities in which to practice?

4. How are these facilities equipped for patient service (type)?

5. Who provides the financial resources to operate patient services?

6. What are the available alternatives for purchasing ancillary services?

7. Why is this an attractive setting in which to practice medicine?

E. Fees

1. By what process is a fee schedule determined?

2. Who is accountable for adhering to the fee schedule?

3. How is collection of professional fees facilitated by the plan?

4. Which aspects of fee management (billing, collection and disbursement) are best handled through the plan?

5. What other options for fee management have been considered or proposed?

F. Income Distribution

1. How is the level of patient service activity enhanced (limited) by the formula for distribution of related revenue?

2. What is the relationship between patient service activity and salary level?

3. How is income flowing through the plan used to support other faculty activities, e.g., teaching, research and administration?

4. Where are the sources of pressure(s) for changing the allocation of plan income?

5. How can plan participants who have the privilege, but lack the opportunity, for earning supplemental income be fully compensated?

6. What professionally-related expenditures are specified by the plan as permissible for the participants?

7. Who is responsible for recommending adjustment(s) in allocation of patient service-related income?

8. What are the assets (liabilities) of the current distribution scheme?

9. What is the effect on the level of state appropriations to a public medical school with a practice plan generating fee-for-service income?

10. How available is a statement of medical practice plan revenues and expenditures to non-plan participants?

G. Self-Evaluation

1. What procedures are used to evaluate the level of success in meeting plan objectives?

2. Who participates in this evaluation process?

3. When does plan review occur?

4. How are the results of the evaluation translated into modifications of the plan?

APPENDIX D

Sample Letter Sent to Medical School
Requesting Approval of Written Case Study

association of american medical colleges

August 26, 1977

Dear Dr.

I am enclosing a draft of our written case study of your Physician Practice Plan for your comment. I am also sending a copy along to Dr. and to Mr. for their review as well. We are fully appreciative of the fact that the subject of medical practice plans is frequently a very sensitive one in many schools. Therefore, we have made every effort in this draft to mask information that could be traceable to your particular school. If we have been in any way indelicate with comments made in the report, please feel free to call this to our attention. We want to make very sure that you are completely satisfied that what is said in this case study will not cause you any discomfort when it appears along with the other anonymous studies in a national publication.

Again we very much appreciate your efforts and that of your faculty and staff for your cooperation in this project and the courtesies extended to the site team.

Sincerely,

William C. Hilles
Associate Director
Division of Operational Studies

WCH:dl
Enclosure: Draft of case study

cc:

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100